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<b>State:</b>	Arkansas	<b>Filing Company:</b>	Federal Insurance Company
<b>TOI/Sub-TOI:</b>	H21 Health - Other/H21.000 Health - Other		
<b>Product Name:</b>	ACCIDENT AND SICKNESS LIMITED BENEFIT CASH POLICY		
<b>Project Name/Number:</b>	Chubb-ASHIP/Chubb-ASHIP		

## Filing at a Glance

Company:	Federal Insurance Company
Product Name:	ACCIDENT AND SICKNESS LIMITED BENEFIT CASH POLICY
State:	Arkansas
TOI:	H21 Health - Other
Sub-TOI:	H21.000 Health - Other
Filing Type:	Form
Date Submitted:	12/28/2012
SERFF Tr Num:	CLTR-128819794
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	ASHIP5000
Implementation	On Approval
Date Requested:	
Author(s):	Susan Coulter, Frank Cripps, Wendy Hicks, Eve Indradat
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	01/03/2013
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

**State:** Arkansas  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** ACCIDENT AND SICKNESS LIMITED BENEFIT CASH POLICY  
**Project Name/Number:** Chubb-ASHIP/Chubb-ASHIP

**Filing Company:** Federal Insurance Company

## General Information

Project Name: Chubb-ASHIP  
Project Number: Chubb-ASHIP  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Group Market Type: Employer, Association, Trust  
Filing Status Changed: 01/03/2013  
State Status Changed: 01/03/2013  
Created By: Frank Cripps  
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Group  
Group Market Size: Small and Large  
Overall Rate Impact:

Deemer Date:  
Submitted By: Frank Cripps

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

FEDERAL INSURANCE COMPANY

NAIC: 20281 FEIN: 131963496

ACCIDENT AND SICKNESS LIMITED BENEFIT CASH POLICY

FORMS: ASHIP5000 GROUP POLICY

ASHIP 1000-AR STATE AMENDATORY ENDORSEMENT

ASHIP5000-DOC AR DESCRIPTION OF COVERAGE

ASHIP3000 GROUP APPLICATION

ASHIP1001 CHANGE ENDORSEMENT

ASHIP1002 TRUST PARTICIPANT RIDER

Consumer Information Notice

Dear Sir or Madam:

On behalf of Federal Insurance Company, Coulter and Associates, Inc. is filing the attached group limited benefits forms for your review and approval. The product will be marketed through employer groups, associations and any other group that is eligible as per your state laws. The Company is aware that associations must be submitted for prior approval before a policy can be issued. The benefits that are offered on an indemnity cash basis with no medical expense component includes: hospital admission indemnity, in-hospital indemnity, recuperation indemnity benefit, recuperation indemnity, intensive care unit indemnity, in-hospital physician visit indemnity, physician office visit indemnity, emergency room indemnity, surgical indemnity benefit, anesthesia indemnity benefit, ground ambulance transportation indemnity, air ambulance transportation indemnity, diagnostic x-ray and laboratory indemnity, advanced diagnostic test indemnity benefit, patient comfort expense benefit, pet care benefit, immediate family member travel expense benefit, loss of income benefit, and wellness benefit.

Additional benefits offered are accidental death and dismemberment, fracture, dislocation, tendon(s)/ligament(s)/rotator cuff(s), and torn knee cartilage benefits. Dependents coverage is available. The State-Specific Amendment Rider is intended to modify the policy to comply with state requirements. Any changes made by use of the State-Specific Amendment Rider will cause the Description of Coverage issued to the residents of your state to be modified accordingly.

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Variable data is bracketed and may vary from case to case. Amounts may vary or provisions may be modified to fit a specific Policyholder's request. Variable data will never exclude or limit provisions required by the jurisdiction in which the policy is issued. Numerical data will comply with state minimum requirements. Bracketed text may be omitted if it does not apply. Some definitions, for example, are bracketed. If the term is not used because it is related to an optional benefit that is not selected, then the term will be omitted as inapplicable.

This is a new filing for Federal Insurance Company and no forms are replaced by this filing.

If you have any questions, please call me at 609-443-7540 or email me at frank@coulter-and-associates.com. Otherwise we look forward to your approval.

Very truly yours,

Frank Cripps  
Coulter & Associates

## Company and Contact

### Filing Contact Information

Frank Cripps, Consultant  
379 Princeton-Hightstown Rd  
Cranbury, NJ 08512

frank@coulter-and-associates.com  
609-443-7540 [Phone]  
609-443-4103 [FAX]

### Filing Company Information

(This filing was made by a third party - coulterandassociatesinc)

Federal Insurance Company	CoCode: 20281	State of Domicile: Indiana
15 Mountainview Rd	Group Code: 20281	Company Type: property and
Warren, NJ 07059	Group Name: CHUBB	casualty
(609) 443-7540 ext. [Phone]	FEIN Number: 13-1963496	State ID Number:

## Filing Fees

Fee Required?	Yes
Fee Amount:	\$245.00
Retaliatory?	Yes
Fee Explanation:	IN Fees: \$35 per form (x 7 forms) = \$245.00
Per Company:	No

Company	Amount	Date Processed	Transaction #
Federal Insurance Company	\$245.00	12/28/2012	66086252
Federal Insurance Company	\$105.00	01/02/2013	66171493

<b>SERFF Tracking #:</b>	CLTR-128819794	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	ASHIP5000
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Federal Insurance Company		
<b>TOI/Sub-TOI:</b>	H21 Health - Other/H21.000 Health - Other				
<b>Product Name:</b>	ACCIDENT AND SICKNESS LIMITED BENEFIT CASH POLICY				
<b>Project Name/Number:</b>	Chubb-ASHIP/Chubb-ASHIP				

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/03/2013	01/03/2013

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Additional Filing Fees	Note To Reviewer	Frank Cripps	01/02/2013	01/02/2013

<b>SERFF Tracking #:</b>	CLTR-128819794	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	ASHIP5000
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Federal Insurance Company		
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<b>Project Name/Number:</b>	Chubb-ASHIP/Chubb-ASHIP				

## Disposition

Disposition Date: 01/03/2013

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Filing Authorization	Approved-Closed	Yes
Form	Group Policy	Approved-Closed	Yes
Form	AR State Amendatory Endorsement	Approved-Closed	Yes
Form	Description of Coverage	Approved-Closed	Yes
Form	Group Application	Approved-Closed	Yes
Form	Change Endorsement	Approved-Closed	Yes
Form	Trust Participant Rider	Approved-Closed	Yes
Form	AR Consumer Information Notice	Approved-Closed	Yes

**State:** Arkansas**Filing Company:** Federal Insurance Company**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other**Product Name:** ACCIDENT AND SICKNESS LIMITED BENEFIT CASH POLICY**Project Name/Number:** Chubb-ASHIP/Chubb-ASHIP

## Note To Reviewer

**Created By:**

Frank Cripps on 01/02/2013 06:37 AM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

01/03/2013 02:08 PM

**Subject:**

Additional Filing Fees

**Comments:**

We apparently misread the new fees as being a flat \$50 per initial filing. Upon re-reading, we now think it should have been \$50 per form, which is greater than the fee (\$35 per form) for the Company's domicile state. We have submitted an additional \$105 to make up the difference.

SERFF Tracking #:

CLTR-128819794

State Tracking #:

Company Tracking #:

ASHIP5000

State: Arkansas

Filing Company:

Federal Insurance Company

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Product Name: ACCIDENT AND SICKNESS LIMITED BENEFIT CASH POLICY

Project Name/Number: Chubb-ASHIP/Chubb-ASHIP

## Form Schedule

### Lead Form Number: ASHIP5000

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 01/03/2013	Group Policy	ASHIP5000	POLA	Initial		50.900	HIP - Chubb Policy ASHIP5000 12-18-12 final untracked.pdf
2	Approved-Closed 01/03/2013	AR State Amendatory Endorsement	ASHIP 1000-AR 12/12	POLA	Initial			AR - State Endorsement for ASHIP (ASHIP-1000-AR).pdf
3	Approved-Closed 01/03/2013	Description of Coverage	ASHIP5000-DOC AR	CER	Initial		50.800	HIP - DOC Final AR.pdf
4	Approved-Closed 01/03/2013	Group Application	ASHIP3000	AEF	Initial			HIP - Chubb Group Application ASHIP3000 11-27-2012.pdf
5	Approved-Closed 01/03/2013	Change Endorsement	ASHIP1001	POLA	Initial		57.700	Change Endorsement for ASHIP _ASHIP 1001_.pdf
6	Approved-Closed 01/03/2013	Trust Participant Rider	ASHIP1002	POLA	Initial		56.600	Trust Participant Endorsement for ASHIP _ASHIP 1002_.pdf

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Lead Form Number: ASHIP5000								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
7	Approved-Closed 01/03/2013	AR Consumer Information Notice	Consumer Information Notice	OTH	Initial			AR CONSUMER INFORMATION NOTICE.pdf

#### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages





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**[ACCIDENT AND] SICKNESS LIMITED BENEFIT CASH  
POLICY**

Issued by  
Federal Insurance Company

FOR

**[POLICYHOLDER]**

[Producer: XYZ, Inc.]  
[123 Any Street]  
[Any town, Any State]  
[Attn: John Smith]

Chubb Underwriting Office: Federal Insurance Company  
[15 Mountain View Road]  
[P O BOX 1615]  
[Warren, New Jersey 07061-1615]

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*Words and phrases that appear in **bold** print have special meanings and are defined in the Definitions section(s) of this policy. Defined terms include the plural.*

*Throughout this policy the words "**We**", "**Us**" and "**Our**" refer to the **Company** providing this insurance.*

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**Please Read This Policy Carefully**

**Important Notice: The insurance provided under this policy provides limited benefits. Benefits are supplemental and not intended to cover medical expenses. A Covered Person should maintain a separate comprehensive health insurance coverage plan.**

**[This policy does not provide Medicare Supplement Coverage. If a Covered Person is eligible for Medicare by reason of age, review the Guide to Health Insurance for People with Medicare available from Us]**

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## Insuring Agreement

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### Section I

*Chubb Group of Insurance Companies  
15 Mountain View Road, P.O. Box 1615  
Warren, New Jersey 07061-1615*

**Policyholder's Name and Address:**

[ABC, Inc.]  
[123 Main Street]  
[PO Box 123245]  
[Town, State, USA]

Policy Number: [1234-56 - 7890]

Effective Date: [01 - 01 - 2013]

Anniversary Date: [January 1]

*Issued by the stock insurance company  
indicated below:*

**FEDERAL INSURANCE COMPANY**

Incorporated under the laws of  
INDIANA

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### Section II Policy Period and Company

**Policy Effective Date:**

**Policy Period**

From:	[01 - 01 -2013]	To:	[01-01-2014]	[until terminated]
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12:01 A.M. local time at the **Policyholder's** address shown in Section I of the Insuring Agreement.

This insurance is provided by the **Company** in consideration of payment of the required premium.

The insurance under this policy begins on the Effective Date shown in Section I of the Insuring Agreement. The insurance under this policy ends on the last day of the Policy Period shown in Section II of the Insuring Agreement.

The **Policyholder's** acceptance of this policy terminates any prior policy of the same policy number, effective with the inception of this policy.

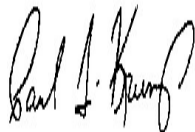
[This policy replaces Policy Number XXXX underwritten by XXXXX as of this policy's effective date.]

### Company

The **Company** issuing this policy has caused this policy to be signed by its authorized officers, but this policy shall not be valid unless also signed by a duly authorized representative of the **Company**.

**FEDERAL INSURANCE COMPANY** (Incorporated under the laws of Indiana)

/



President



Secretary



## Premium Summary

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**Initial Premium Due Date:**

**Premium Payment:**

The **Policyholder** shown in Section I of the Insuring Agreement [or **Our** designated representative] is responsible for the collection and remittance of all premiums. Premiums are calculated and payable as follows:

Class	[Monthly] Rate per person	Premium Due Date
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**REPORTING:**

Reporting Period

Premium Payment

[Monthly]

## Schedule of Benefits

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*Chubb Group of Insurance Companies  
15 Mountain View Road, P.O. Box 1615  
Warren, New Jersey 07061-1615*

**Policyholder's Name:**

[ABC, Inc.]

*Issued by the stock insurance company  
indicated below:*

**FEDERAL INSURANCE COMPANY**  
Incorporated under the laws of  
INDIANA

---

### SECTION I – COVERED PERSONS

The following are eligible to be **Covered Persons** under this policy:

<b>Class</b>	<b>Description</b>
[1]	[All [Members] [Employees] of the <b>Policyholder</b> ]
[2]	[All <b>Spouses</b> [or <b>Domestic Partners</b> ] of Class 1 <b>Insured Persons</b> ]
[3]	[All <b>Dependent Children</b> of Class 1 <b>Insured Persons</b> ]
[4]	[Additional Classes as defined by the Policyholder.]

If, subject to all the terms and conditions of this policy a person is eligible for insurance under multiple **Classes** of **Covered Persons** described above, then such person will only be insured under the **Class** which provides the **Covered Person** the largest **Benefit Amount** for the loss that has occurred.

### SECTION II – BENEFITS

Benefits are provided [worldwide][in the United States including its territories and jurisdictions.]

Benefits are payable based on the **Plan Year** as follows: [**Calendar Year**][**Policy Year**][**Description of Coverage Year**]

The **Insured Person** is paid at 100% of the **Benefit Amount** listed below for any loss covered under this policy.

[The covered **Spouse** [or covered **Domestic Partner**] is paid at [50%-100%] of the **Benefit Amount** listed below for any loss covered under this policy. ]

[The covered **Dependent Child** is paid at [10-100%] of the **Benefit Amount** listed below for any loss covered under this policy. ]

#### [Hospital Admission Indemnity Benefit]

<b>Class:</b> [All]	<b>Benefit Amount per Hospital admission:</b> [\$XXX]
	Maximum number of admissions [per] [ <b>Sickness</b> ][or][ <b>Accident</b> ] [per <b>Plan Year</b> ]: [X]

#### [In-Hospital Indemnity Benefit]

<b>Class:</b> [All]	Daily <b>Benefit Amount:</b> [\$300]
---------------------	--------------------------------------

	<b>[Elimination Period for Sickness:[0-7 days]]</b> <b>[Elimination Period for Accident:[0-7 days]]</b>  [Retroactive Benefit: <input type="checkbox"/> yes <input type="checkbox"/> no]
	Maximum Number of Days per <b>[Period of Confinement]</b> [ <b>Sickness</b> [or <b>Accident</b> ] [per <b>Plan Year</b> ]: [90]
	[Maximum <b>Benefit Amount</b> per <b>[Sickness ]</b> [and <b>Accident</b> combined] [per <b>Plan Year</b> ]: [\$100,000]]

]

[Recuperation Indemnity Benefit

<b>Class:</b> [All]	Daily <b>Benefit Amount:</b> [\$100]
	[Maximum <b>Benefit Amount</b> per <b>Plan Year</b> :]: [\$100,000] ]

]

[Intensive Care Unit Indemnity Benefit

<b>Class:</b> [All]	Daily <b>Benefit Amount:</b> [\$600]
	<b>[Elimination Period for Sickness:[0-7 days]]</b> <b>[Elimination Period for Accident:[0-7 days]]</b>  [Retroactive Benefit: <input type="checkbox"/> yes <input type="checkbox"/> no]
	Maximum Number of Days per <b>[Period of Confinement]</b> [ <b>Sickness</b> [or <b>Accident</b> ] [per <b>Plan Year</b> ]: [90]
	[Maximum <b>Benefit Amount</b> [per <b>Sickness</b> ] [and <b>Accident</b> combined] [per <b>Plan Year</b> ]: [\$200,000]]

]

[In-Hospital Physician Visit Indemnity Benefit

<b>Class:</b> [All]	Per Visit <b>Benefit Amount:</b> [\$XX]
	Maximum Number of visits per <b>Period of Confinement</b> [regardless of the number of visiting <b>Physicians</b> ]: [X]

]

[Physician Office Visit Indemnity Benefit

<b>Class:</b> [All]	Per Visit <b>Benefit Amount:</b> [\$XX]
	Maximum number of visits [per] <b>[Sickness]</b> [or] <b>[Accident]</b> [per <b>Plan Year</b> ]: [X]

]

[Emergency Room Indemnity Benefit

<b>Class:</b> [All]	Per Visit <b>Benefit Amount:</b> [\$xx]
	Maximum number of emergency room visits [per] <b>[Sickness]</b> [or] <b>[Accident]</b> [ <b>Plan Year</b> ]: [X]

]

[Surgical Indemnity Benefit

<b>Class:</b> [All]		<b>Benefit Amount</b>
	[Benefit Amount per In-Hospital Major Surgical Procedure per Covered Person per Plan Year	[\$500 -\$10,000]]
	[Benefit Amount per Major Surgical Procedure performed in an Outpatient Unit per Covered Person per Plan Year	[\$500-\$5,000]]
	[Benefit Amount per In-Hospital Minor Surgical Procedure per Covered Person per Plan Year	[\$0 -\$500]]
	[Benefit Amount per Minor Surgical Procedure performed in an Outpatient Unit per Covered Person per Plan Year	[\$0 -\$500]]
	[Maximum Number of In-Hospital Procedures per Covered Person per Plan Year regardless of whether a Major or Minor Surgical Procedure	[1-10]]
	[Maximum Number of Outpatient Unit Procedures per Covered Person per Plan Year regardless of whether a Major or Minor Surgical Procedure	[1-10]]

]

[Anesthesia Indemnity Benefit

<b>Class:</b> [All]		<b>Benefit Amount</b>
	[Benefit Amount per covered Major Surgical Procedure per Covered Person	[\$100- \$2,000 ]]
	[Benefit Amount per covered Minor Surgical Procedure per Covered Person	[\$0 - \$200]]

]

[Ground Ambulance Transportation Indemnity Benefit

<b>Class:</b> [All]	Per trip <b>Benefit Amount:</b> [\$XX]
	Maximum number of ground ambulance trips per [Sickness][and][Accident] [per <b>Plan Year</b> ] [x]

]

[Air Ambulance Transportation Indemnity Benefit

<b>Class:</b> [All]	Per trip <b>Benefit Amount:</b> [\$XX]
	Maximum number of air ambulance trips per [Sickness][and][Accident] [ per <b>Plan Year</b> ]: [X]

]

[Diagnostic X-Ray and Laboratory Indemnity Benefit

<b>Class:</b> [All]	<b>Benefit Amount</b> per test per Covered Person: [\$10-\$100]
	Maximum number of X-rays and tests per Covered Person per Plan Year [1-6]

]

**[Advanced Diagnostic Test Indemnity Benefit**

<b>Class:</b> [All]	<b>Per test per Covered Person per Plan Year:</b> [\$xxxx]
	<b>Maximum number of tests per Covered Person per Plan Year:</b> [ XX]

**[Patient Comfort Expense Benefit**

<b>Class:</b> [All]	<b>Maximum Benefit Amount per Period of Confinement for all Patient Comfort Expenses :[\$XX]</b>
---------------------	--

**[Pet Care Benefit**

<b>Class:</b> [All]	<b>Benefit Amount per day of In-Hospital:</b> [\$xx]
	<b>Maximum Benefit Amount per Period of Confinement:</b> [\$XX]

**[Immediate Family Member Travel Expense Benefit**

<b>Class:</b> [All]	
	<b>Number of Days of consecutive In-Hospital before Benefit Amount payable:</b> [3]
<b>Traveling Expenses:</b>	<b>Daily Benefit Amount:</b> [\$xx]
	<b>Maximum Number of Days per Immediate Family Member:</b> [x]
	<b>Maximum number of Immediate Family Members:</b> [X]
	<b>Number of Miles between primary residence and Hospital:</b> [X]

**Loss of Income Benefit**

<b>Class:</b> [All]	<b>Benefit Amount per day of In-Hospital regardless of number of parents:</b> [\$xx]
	<b>Maximum Number of Days per In-Hospital:</b> [x]

**[Wellness Indemnity Benefit**

<b>Class:</b> [All]	<b>One preventive screening test per Covered Person per Plan Year:</b> [\$25-200]
---------------------	---

**ADDITIONAL ACCIDENT BENEFITS**

**[Accidental Death and Dismemberment Benefit**

<b>[Class] [1]</b>	<b>Loss of Life Benefit Amount:</b> [\$200,000]
<b>[Class] [2]</b>	<b>Loss of Life Benefit Amount:</b> [50% of the Class 1 Insured Person's Loss of Life Benefit Amount]
<b>[Class] [3]</b>	<b>Loss of Life Benefit Amount:</b> [15% of the Class 1 Insured Person's Loss of Life Benefit Amount]



The following are **Losses** insured and the corresponding **Benefit Amounts** expressed as a percentage of the **Loss of Life Benefit Amount**:

<b>Accidental:</b>	<b>Percent of Loss of Life Benefit Amount</b>
<b>Loss of Life</b>	[100%]
<b>Loss of Speech and Loss of Hearing</b>	[100%]
<b>Loss of Speech and Loss of one of: Hand, Foot or Sight of an Eye</b>	[100%]
<b>Loss of Hearing and Loss of one of: Hand, Foot or Sight of an Eye</b>	[100%]
<b>Loss of Both Hands, Loss of Both Feet, Loss of Sight of Both Eyes or a combination of any two of Loss of Hand, Loss of Foot or Loss of Sight of an Eye</b>	[100%]
<b>[Quadriplegia]</b>	[100%]
<b>[Paraplegia]</b>	[75%]
<b>[Hemiplegia]</b>	[50%]
<b>Loss of One Hand, Loss of One Foot or Loss of Sight of an Eye</b>	[50%]
<b>Loss of Speech or Loss of Hearing</b>	
<b>[Uniplegia]</b>	[25%]
<b>Loss of Thumb and Index Finger</b>	[25%]

**[Fracture Benefit]**

<b>[Class] [1]</b>	<b><u>Fracture</u></b>	<b>Closed/Open Reduction Benefit Amount for each Fracture</b>
	Skull-depressed (except bones of the face or nose)	<u>XXXXX/XXXX</u>
	Skull-simple (except bones of the face or nose)	<u>XXXXX/XXXX</u>
	Hip or thigh (femur)	<u>XXXXX/XXXX</u>
	Pelvis (except coccyx), Vertebrae (except processes) , Leg (tibia and/or fibula),	<u>XXXXX/XXXX</u>
	Vertebral processes	<u>XXXXX/XXXX</u>
	Arm, between shoulder and elbow (shaft)	<u>XXXXX/XXXX</u>
	Upper Jaw, Maxilla (except Alveolar Process)	<u>XXXXX/XXXX</u>
	Shoulder blade (scapula), Collarbone (clavicle, sternum)	<u>XXXXX/XXXX</u>
	Knee cap (patella), Ankle, Foot (except toes)	<u>XXXXX/XXXX</u>
	Forearm (radius or ulna), hand or wrist (except fingers)	<u>XXXXX/XXXX</u>
	Lower jaw (except alveolar process)	<u>XXXXX/XXXX</u>
	Rib	<u>XXXXX/XXXX</u>
	Bones of face or nose	<u>XXXXX/XXXX</u>
	Finger , Toe	<u>XXXXX/XXXX</u>
	Coccyx	<u>XXXXX/XXXX</u>

If the **Physician** diagnoses a **Chip Fracture**, We will pay [25%] of the Closed Reduction amount listed above.]

**[Dislocation Benefit]**

<b>[Class] [1]</b>	<b><u>Dislocation</u></b>	<b>Closed/Open Reduction Benefit Amount for each Dislocation</b>
	Hip	<u>XXXXX/XXXX</u>
	Knee (except patella)	<u>XXXXX/XXXX</u>
	Ankle-bone(s) of foot (except toes)	<u>XXXXX/XXXX</u>

	Collarbone (sternoclavicular)	<u>XXXX/XXXX</u>
	Lower Jaw, Shoulder, Elbow or Wrist	<u>XXXX/XXXX</u>
	Hand bone(s) (except fingers)	<u>XXXX/XXXX</u>
	Collarbone (Acromioclavicular and separation)	<u>XXXX/XXXX</u>
	One finger or one toe	<u>XXXX/XXXX</u>
		<u>XXXX/XXXX</u>

If the **Dislocation** requires reduction without anesthesia by a **Physician**, We will pay [25%] of the Closed Reduction amount listed above.]

[Tendon(s) / Ligament(s) / Rotator Cuff(s) Benefit:

[Class] [1]	Torn, Ruptured or Severed Tendon / Ligament / Rotator Cuff	Benefit Amount
	Surgical repair: one tendon/ligament/rotator cuff	\$XXX per <b>Accident</b>
	Surgical repair: two or more tendons/ligaments/rotator cuffs	\$XXX per <b>Accident</b>
	Exploratory Surgery without repair	\$XXX per <b>Accident</b>

]

[Torn Knee Cartilage Benefit

[Class] [1]	Torn Knee Cartilage	Benefit Amount
	With surgical repair	\$XXX per knee per <b>Accident</b>
	Exploratory Surgery without repair	\$XXX per knee per <b>Accident</b>

]

[REDUCTION OF **BENEFIT AMOUNT** FOR ALL BENEFITS PROVIDED

[If a **Covered Person** is age [70] or older on the date of a loss covered under this policy, the benefit otherwise payable will be reduced according to the following schedule:

Age on Date of Loss:	Amount of <b>Benefit Amount</b> after Reduction:
65	[50%] of the <b>Benefit Amount</b> otherwise payable to the <b>Covered Person</b>
[75]	[25%] of the <b>Benefit Amount</b> otherwise payable to the <b>Covered Person</b>

[The **Benefit Amount** cannot be increased by the **Insured Person** after age [sixty-five (65)].] ]

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## Contract

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### SECTION I – INSURANCE

Subject to all the terms and conditions of this policy and the payment of required premium, **We** will provide the following insurance for the losses described below:

#### [Hospital Admission Indemnity Benefit

**We** will pay a **Hospital Admission Benefit** if a **Covered Person** is admitted to a **Hospital** and **Confined** due to **Sickness** [or as the result of an **Accident**]. [The **Covered Person** must become **Confined** within [6] months after the covered **Accident**]. No benefit will be paid for:

- 1) [emergency room treatment;]
- 2) [outpatient treatment;] [or]
- 3) [a stay of less than 20 hours in an observation unit].

The **Benefit Amount** is shown in Section II of the Schedule of Benefits.

[**We** will not pay more than the Maximum number of admissions as shown in Section II of the Schedule of Benefits.]]

#### [In-Hospital Indemnity Benefit

**We** will pay the daily **In-Hospital Benefit Amount** [after the **Elimination Period** both] shown in Section II of the Schedule of Benefits, for each day a **Covered Person** is **In-Hospital** due to a **Sickness** [or **Accident**]. [The first day of a **Hospital** stay must occur within [thirty (30)] days of the **Accident**, causing the Injury.]

[If a **Covered Person** is initially **Confined** in a **Hospital**, before benefits are payable under the policy, the **Covered Person** must satisfy the **Elimination Period** which means that the **Covered Person** must be **Confined** in a **Hospital** for the number of consecutive days shown in Section II of the Schedule of Benefits. [If the **Period of Confinement** starts with **Intensive Care Unit Confinement** and the **Covered Person** has satisfied the **Elimination Period** and then is moved to a regular **Hospital** room, then no additional **Elimination Period** must be satisfied. If the **Period of Confinement** starts with **Intensive Care Unit Confinement** and the **Covered Person** has not satisfied the **Elimination Period** and then is moved to a regular **Hospital** room the **Elimination Period** must be satisfied taking into account both **In-Hospital** and **Intensive Care Unit Confinements**. ] ]

The **In-Hospital Benefit Amount** will be paid until the earliest of the date the:

- 1) **Covered Person** dies;
- 2) **Covered Person** is no longer **In-Hospital**; or
- 3) Maximum Number of Days, shown in Section II of the Schedule of Benefits, has elapsed; or
- 4) Maximum **Benefit Amount** has been paid.

[A **Confinement** for a **Sickness** shall not be combined with another **Confinement** for an **Accident** in determining a **Period of Confinement**.]

If a **Covered Person** is discharged from the **Hospital** and a different **Sickness** [or **Accident**] causes such **Covered Person** to be **In-Hospital** again after [1day] of non-confinement, then **We** will consider it a new **Period of Confinement**. If a **Covered Person** is discharged from the **Hospital** and readmitted for the same [**Sickness**] [or **Accident**] as the prior **Period of Confinement** within [180 days] of the prior **Period of Confinement**'s discharge, it will be considered the same **Period of Confinement**. If it is considered the same **Period of Confinement** then a **Covered Person** will not have to satisfy a new **Elimination Period** but is subject to the same Maximum Number of Days and any Maximum **Benefit Amounts** shown in Section II of the Schedule of Benefits for that[ **Sickness**] [or **Accident**]. If it is considered a new **Period of Confinement**, then a new **Elimination Period** must be satisfied but the **Covered Person** is entitled to a new Maximum **Benefit Amount**.

[Retroactive Benefit: If a **Covered Person** is **Confined In-Hospital** [or in an **Intensive Care Unit**] for treatment of **Sickness** [or **Accident**] after the **Elimination Period**, **We** will pay the daily **Benefit Amount** retroactively to the first day of **In-Hospital** [or **Intensive Care Unit Confinement**].

[**We** will not pay more than the Maximum **Benefit Amount**, shown in Section II of the Schedule of Benefits.]]

#### [Recuperation Indemnity Benefit

**We** will pay the daily Recuperation **Benefit Amount** shown in Section II of the Schedule of Benefits once the **Covered Person** has been discharged from the **Hospital** if:

- 1) a **Sickness** [or **Accident**] causes a **Covered Person** to be **In-Hospital Confined**; and
- 2) such **Covered Person** received a benefit under the **In-Hospital** Benefit of this policy.

The Recuperation **Benefit Amount** will be paid for the same number of days for which **We** paid the **In-Hospital** Benefit and will be paid in one lump sum after the **Covered Person's** discharge from the **Hospital**. If the **Covered Person** dies while **In-Hospital**, no Recuperation Benefit is payable.

[**We** will not pay more than the Maximum **Benefit Amount**, shown in Section II of the Schedule of Benefits.]]

#### [**Intensive Care Unit** Indemnity Benefit

**We** will pay the daily **Intensive Care Unit Benefit Amount** [after the **Elimination Period** both] shown in Section II of the Schedule of Benefits, for each day of **Confinement** if [an **Accident** or] **Sickness** causes a **Covered Person** to be **Confined** in an **Intensive Care Unit**. [This benefit is paid in addition to the **In-Hospital Benefit Amount**]. [The first day of **Confinement** in the **Intensive Care Unit** must occur within [thirty (30)] days of the **Accident**.]

[If a **Covered Person** is initially **Confined** in an **Intensive Care Unit**, before benefits are payable under the policy, the **Covered Person** must satisfy the **Elimination Period** which means that the **Covered Person** must be **Confined** in an **Intensive Care Unit** for the number of consecutive days shown in Section II of the Schedule of Benefits. If the **Period of Confinement** starts with **In-Hospital Confinement** and the **Covered Person** has satisfied the **Elimination Period** and then is moved to the **Intensive Care Unit**, no additional **Elimination Period** must be satisfied. If the **Period of Confinement** starts with **In-Hospital Confinement** and the **Covered Person** has not satisfied the **Elimination Period** and then is moved to the **Intensive Care Unit**, the **Elimination Period** must be satisfied taking into account both **In-Hospital** and **Intensive Care Unit Confinements**. ]

The **Intensive Care Unit Benefit Amount** will be paid until the earliest of the date:

- 1) the **Covered Person** dies;
- 2) the **Covered Person** is no longer **Confined** in an **Intensive Care Unit**; or
- 3) the Maximum Number of Days, shown in Section II of the Schedule of Benefits, has elapsed.

[A **Confinement** for a **Sickness** in an **Intensive Care Unit** shall not be combined with another **Confinement** in an **Intensive Care Unit** for an **Accident** in determining a **Period of Confinement**.]

If a **Covered Person** is discharged from the **Hospital** and a different **Sickness** [or **Accident**] causes such **Covered Person** to be **Confined** in an **Intensive Care Unit** again after [1day] of non-confinement, then **We** will consider it to be a new **Period of Confinement**. If a **Covered Person** is discharged from the **Hospital** and readmitted to an **Intensive Care Unit** for the same [**Sickness**] [or **Accident**] as the prior **Period of Confinement** within [180 days] of the prior **Period of Confinement's** discharge, it will be considered the same **Period of Confinement**. If it is considered the same **Period of Confinement** then a **Covered Person** will not have to satisfy a new **Elimination Period** but is subject to the same Maximum Number of Days and any Maximum **Benefit Amounts** shown in Section II of the Schedule of Benefits for that [**Sickness**] [or **Accident**]. If it is considered a new **Period of Confinement**, then a new **Elimination Period** must be satisfied but the **Covered Person** is entitled to a new Maximum **Benefit Amount**.

[Retroactive Benefit: If a **Covered Person** is **Confined** in an **Intensive Care Unit** [or **In-Hospital**] for treatment of **Sickness** [or **Accident**] after the **Elimination Period**, **We** will pay the daily **Benefit Amount** retroactively to the first day of [**In-Hospital** or] **Intensive Care Unit Confinement**.]

[**We** will not pay more than the Maximum **Benefit Amount**, shown in Section II of the Schedule of Benefits.]]

#### **[In-Hospital Physician Visit Indemnity Benefit**

**We** will pay the **In-Hospital Physician Visit Indemnity Benefit Amount**, as shown in Section II of the Schedule of Benefits, for a visit by a **Physician** during a **Period of Confinement** in a **Hospital** as a result of [an **Accident** or] **Sickness**. It is not payable for a surgeon's visit in a **Hospital** following a **Major** or **Minor Surgical Procedure**.

[**We** will not pay more than the Maximum **Benefit Amount**, shown in Section II of the Schedule of Benefits.]]

#### **[Physician Office Visit Indemnity Benefit**

**We** will pay the **Physician Office Visit Indemnity Benefit Amount**, as shown in the Section II of the Schedule of Benefits, for a **Physician** office visit as a result of [an **Accident** or] **Sickness**. The visit must be made to the **Physician's** office or clinic. [The visit to a **Physician's** office must occur within [thirty (30)] days of the **Accident**, causing an Injury.]

Benefits are not payable for:

- 1) visits made by a **Physician** while the **Covered Person** is **Confined** in a **Hospital**;
- 2) routine eye examinations, or fitting of glasses or fitting of hearing aids;
- 3) dental examinations or dental care [other than expenses resulting from **Accidental** injury]; or
- 4) Annual physicals, school sports physicals, and other types of preventive visits not required due to [an **Accident** or] **Sickness**.

[**We** will not pay more than the Maximum **Benefit Amount**, shown in Section II of the Schedule of Benefits. ]]

#### **[Emergency Room Indemnity Benefit**

**We** will pay the **Emergency Room Benefit Amount**, shown in Section II of the Schedule of Benefits, if an [**Accident** or] **Sickness** causes the **Covered Person** to require and receive **Emergency Medical Care** in an emergency room of a **Hospital**. [Treatment must be received within [24] hours of the **Accident**. ]

[**We** will not pay more than the Maximum **Benefit Amount** shown in Section II of the Schedule of Benefits. ]]

#### **[Surgical Indemnity Benefit**

**We** will pay the **Surgical Indemnity Benefit** if a **Covered Person** has a **Major** or **Minor Surgical Procedure** performed [while **In-Hospital**] [or] [on an outpatient basis in an **Outpatient Unit**]. The **Benefit Amounts** are shown in Section II of the Schedule of Benefits.

If two or more procedures are performed through the same incision or operative field, payment will be made only for the procedure of the larger benefit. If more than one procedure is performed but each through separate incisions or in a separate operative field, the amount payable shall be the specified amount for the primary procedure plus 50% of the amount payable for all other surgical procedures performed.

[A surgical procedure due to **Accident** must occur within [thirty (30)] days of the **Accident**, causing an Injury. [If the **Major** or **Minor Surgical Procedure** is required for Exploratory Surgery and also payable under the Tendon(s) / Ligament(s) / Rotator Cuff(s) Benefit, **We** will pay only one benefit. That benefit will be the larger of the Surgical Indemnity Benefit and the Tendon(s) / Ligament(s) / Rotator Cuff(s) Benefit. ]

**We** will not pay more than the maximum number of **Major** or **Minor Surgical Procedures** in a **Plan Year** as shown in Section II of the Schedule of Benefits.]

#### **[Anesthesia Indemnity Benefit**

**We** will pay the **Anesthesia Indemnity Benefit** for the administration of anesthesia related to a covered surgical procedure, if the **Surgical Indemnity Benefit** is payable. The **Benefit Amount** is shown in Section II of the Schedule of Benefits.

[Ground Ambulance Transportation Indemnity Benefit

If a **Covered Person** requires the use of an ambulance service by ground for transportation to or from a **Hospital** or from one **Hospital** to another **Hospital** for care and treatment of [an **Accident** or] **Sickness**, **We** will pay the Ground Ambulance Transportation **Benefit Amount** shown in Section II of the Schedule of Benefits. [**We** will not pay more than the Maximum **Benefit Amount** shown in Section II of the Schedule of Benefits.]

[**We** will not pay more than the maximum number of trips shown in Section II of the Schedule of Benefits in a **Plan Year**.]

[Air Ambulance Transportation Indemnity Benefit

If a **Covered Person** requires the use of an ambulance service by air for transportation to or from a **Hospital** or from one **Hospital** to another **Hospital** for care and treatment of [an **Accident** or] **Sickness** **We** will pay the Air Ambulance Transportation **Benefit Amount** shown in the in Section II of the Schedule of Benefits. [**We** will not pay more than the Maximum **Benefit Amount** shown in Section II of the Schedule of Benefits.]

[**We** will not pay more than the maximum number of trips shown in Section II of the Schedule of Benefits in a **Plan Year**.]

[Diagnostic X-Ray and Laboratory Indemnity Benefit

**We** will pay the Diagnostic X-Ray and Laboratory Indemnity Benefit, as shown in Section II of the Schedule of Benefits, when a **Covered Person** has diagnostic x-ray and laboratory tests performed. Such tests and diagnostic x-rays must be ordered by a **Physician** and be related to [an **Accident** or] **Sickness**. This insurance does not pay for x-rays or laboratory tests performed while **Confined** in a **Hospital**. In addition, if a test is payable under the **Advanced Diagnostic Test** Indemnity Benefit, it will be paid under that Benefit and not this Benefit. [Preventive tests are payable under the Wellness Indemnity Benefit and not payable under this Benefit.

[A diagnostic x-ray and laboratory tests performed due to Accident must be done within [thirty (30)] days of the **Accident**, causing an Injury.]

[**We** will not pay more than the number of tests shown in Section II of the Schedule of Benefits in a **Plan Year**.]

[**Advanced Diagnostic Test** Indemnity Benefit

**We** will pay the **Advanced Diagnostic Test** Indemnity Benefit, as shown in Section II of the Schedule of Benefits, when a **Covered Person** has one of the following tests performed: Angiogram /Arteriogram, EEG, Myelogram, CT Scan, MRI Scan, or PET Scan. Such tests must be ordered by a **Physician** and be related to [an **Accident** or] **Sickness**. This insurance does not pay for tests performed while **Confined** in a **Hospital**.

[**We** will not pay more than the number of tests shown in Section II of the Schedule of Benefits in a **Plan Year**.]

[**Patient Comfort Expense** Benefit

**We** will pay the **Covered Person** for **Patient Comfort Expenses** if a **Covered Person** is **Hospital Confined** due to **Sickness** [or **Accident**] and requires a **Hospital** stay for more than [one (1) day[s]]. This benefit is only payable if a **Covered Person** is **In-Hospital** or **Confined** in an **Intensive Care Unit** for which a daily benefit is payable.

In addition to any **Proof of Loss** required under the **Claim Proof of Loss** provision, **We** will require receipts for any covered purchase. Receipts are not required for purchases under \$25.

[**We** will not pay more than the Maximum **Benefit Amount** for any **Period of Confinement**, shown in Section II of the Schedule of Benefits.]

**Patient Comfort Expenses** means:

- 1) [the charge for television, internet, pay-per-view, or other pay media services including internet streaming services not necessarily being charged by the **Hospital**.]

- 2) [the cost of books, magazines, or newspapers for use by the **Confined Covered Person**];
- 3) [the cost of electronic media consumption devices such as E-Readers, tablets, MP3, or MP4 players for use by the **Confined Covered Person**. Electronic media consumption devices does not include cell phones or laptop computers;]
- 4) [charges for phone bills charged by the **Hospital** to the **Covered Person**];
- 5) [any upgrades to meal plans offered by the **Hospital** that are available for purchase.]]

#### [Pet Care Benefit

**We** will pay a benefit for pet care if:

- 1) a **Covered Person** is **Hospital Confined** due to **Sickness** [or **Accident**]; and
- 2) requires a **Hospital** stay for more than [one (1) day[s]; and
- 3) owns a house pet that needs professional care for which a charge is made while he or she is **Hospital Confined**.

**We** will pay the expense incurred for daily pet care for each day that the **Covered Person** is **Hospital Confined** up to the **Benefit Amount** as shown in Section II of the Schedule of Benefits. This benefit is only payable if a **Covered Person** is **In-Hospital** or confined in an **Intensive Care Unit** for which a daily benefit is payable. In addition to any **Proof of Loss** required under the **Claim Proof of Loss** provision, **We** will require receipts for any cost of care. Receipts are not required for daily care under \$25.

[**We** will not pay more than the Maximum **Benefit Amount** for any one period of **In-Hospital Confinement**, shown in Section II of the Schedule of Benefits.]]

#### [Immediate Family Member Travel Expense Benefit

If the **Covered Person's Sickness** [or **Accident**] requires a **Hospital** stay for more than the number of days shown in the in Section II of the Schedule of Benefits, then **We** will reimburse up to the daily **Benefit Amount** for each **Immediate Family Member** up to the maximum number of **Immediate Family Members** shown in Section II of the Schedule of Benefits, if all the following conditions are met:

- 1) the **Covered Person** is confined to a **Hospital**; and
- 2) the **Hospital** is at least the number of miles shown in Section II of the Schedule of Benefits from the **Immediate Family Member's** primary residence;

The daily **Benefit Amount** is shown in Section II of the Schedule of Benefits. **We** will not pay more than the maximum number of days shown in Section II of the Schedule of Benefits per **Immediate Family Member**.

**Immediate Family Member Travel Expenses** means the cost of a **Common Carrier** fare, lodging, and food.

In addition to any **Proof of Loss** required under the **Claim Proof of Loss** provision, **We** will require receipts for any **Immediate Family Member Travel Expenses**. Receipts are not required for travel expenses under \$25. ]

#### [Loss of Income Benefit

**We** will pay the daily Loss of Income **Benefit Amount** to each parent, [**Spouse**][**Domestic Partner**] of a **Covered Person** up to the maximum number of days for Loss of Income shown in Section II of the Schedule of Benefits. The Loss of Income benefit shall only be provided if:

- 1) the **Covered Person** is **In-Hospital** for which a daily benefit is payable under this policy;
- 2) the parent [**Spouse**][**Domestic Partner**] of a **Covered Person** is gainfully employed during the time that the **Covered Person** remains **In-Hospital**;
- 3) the parent's [**Spouse's**][**Domestic Partner's**] time off is deducted from his or her daily salary or wages;
- 4) the daily Loss of Income **Benefit Amount** for such parent, [**Spouse**][**Domestic Partner**] doesn't exceed the daily salary or wages for such parent, [**Spouse**] [**Domestic Partner**]. If the daily **Benefit Amount** for Loss of Income exceeds the daily salary or wages for such parent, [**Spouse**][**Domestic Partner**], **We** will only pay up to the amount that would have been paid by his or her employer.]

In addition to any **Proof of Loss** required under the **Claim Proof of Loss** provision, **We** will require:

- 1) written proof from the parent's, [Spouse's][Domestic Partner's] employer that the time off was deducted from the daily salary or wage; and
- 2) written proof of the daily salary or wages lost by the parent, [Spouse] [Domestic Partner]. ]

#### [Wellness Indemnity Benefit

**We** will pay this benefit if the **Insured Person** [or the **Insured Person's** covered [Spouse][or Domestic Partner]] has one of the following screening tests performed while coverage under the Policy which is in force. **We** will pay the **Benefit Amount** shown in Section II of the Schedule of Benefits. This benefit is payable once per **Plan Year** per **Insured Person** [or the **Insured Person's** covered [Spouse][or Domestic Partner]. If the benefit is be payable under the Diagnostic X-Ray and Laboratory Indemnity Benefit or the Surgical Indemnity Benefits as it relates to [an **Accident** or] **Sickness**, it will be paid under that benefit and not this Wellness Indemnity Benefit.

Screening test is defined as:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (cancer antigen 15-3 - blood test for breast cancer)
- CA125 (cancer antigen 125 - blood test for ovarian cancer)
- CEA (carcinoembryonic antigen - blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum Protein Electrophoresis (blood test for myeloma)
- Thermography
- ThinPrep Pap Test
- Virtual Colonoscopy ]

#### [ADDITIONAL ACCIDENT BENEFITS

##### [Accidental Death and Dismemberment Benefit

**We** will pay the applicable **Benefit Amount**, shown in Section II of the Schedule of Benefits, if an **Accident** results in a **Loss** covered under this policy and not otherwise excluded. The **Accident** must occur while a **Covered Person** is insured under this policy, while it is in force. The **Loss** must occur within one (1) year after the **Accident**.]

##### [Fracture Benefit

**We** will pay the applicable **Benefit Amount** if an **Accident** results in a **Fracture** as shown in Section II of the Schedule of Benefits. The **Accident** must occur while a **Covered Person** is insured under this policy, while it is in force. The **Fracture** must be diagnosed as a **Fracture** by a **Physician** within [90, 180, 365] days after the **Accident**. The **Fracture** requires correction by a **Physician**. It can be corrected by Open (surgical) or Closed (non-surgical) Reduction.

If a **Covered Person** sustains more than one **Fracture** in the same **Accident**, and requires Open or Closed Reduction, payment will be made for all **Fractures**. However, payment will not exceed more than two times the amount of the bone involved which has the highest **Benefit Amount** as shown in Section II of the Schedule of Benefits.

If the **Physician** diagnoses a **Chip Fracture**, **We** will pay a reduced benefit as shown in Section II of the Schedule of Benefits.



[If a **Covered Person** sustains a **Fracture** and a **Dislocation** in the same **Accident**, payment will be made for both. However, payment will not exceed two times the amount of the bone or joint involved which has the highest **Benefit Amount**.]

**[Dislocation Benefit]**

**We** will pay the applicable **Benefit Amount** if an **Accident** results in a **Dislocation** as shown in Section II of the Schedule of Benefits. The **Accident** must occur while a **Covered Person** is insured under this policy, while it is in force. The **Dislocation** must be diagnosed by a **Physician** within [90, 180, 365] days after the **Accident**. The **Dislocation** requires correction with anesthesia by a **Physician**. It can be corrected by Open (surgical) or Closed (non-surgical) Reduction.

If a **Covered Person** sustains more than one **Dislocation** in the same **Accident**, and requires Open or Closed Reduction, payment will be made for all **Dislocations**. However, payment will not exceed more than two times the amount of the joint involved which has the highest **Benefit Amount** as shown in Section II of the Schedule of Benefits.

If the **Dislocation** requires reduction without anesthesia by a **Physician**, **We** will pay a reduced benefit as shown in Section II of the Schedule of Benefits.

This benefit will only be paid once for the first **Dislocation** of a joint after the **Covered Person's** effective date of coverage. Subsequent **Dislocations** of the same joint after such effective date will not be covered.

[If a **Covered Person** sustains a **Fracture** and a **Dislocation** in the same **Accident**, payment will be made for both. However, payment will not exceed two times the amount of the bone or joint involved which has the highest **Benefit Amount**.]

**[Tendon(s)/Ligament(s)/Rotator Cuff(s) Benefit]**

**We** will pay the **Benefit Amount** as shown in Section II of the Schedule of Benefits if:

- 1) a **Covered Person's Accident** results in injuries to a tendon, ligament, or rotator cuff;
- 2) the tendon, ligament or rotator cuff is torn, ruptured or severed; and
- 3) must be repaired through surgery by a **Physician** within [90, 180, 365] days after the **Accident**.

The **Accident** must and occur while a **Covered Person** is insured under this policy, while it is in force.

If Exploratory Surgery is performed and no repair is done, **We** will pay the **Benefit Amount** for Exploratory Surgery without repair as shown in Section II of the Schedule of Benefits in lieu of the Tendons/Ligament/Rotator Cuff **Benefit Amount**.

If a **Covered Person** sustains a **Fracture** or a **Dislocation** and tears, ruptures, or severs a tendon, ligament, or rotator cuff in the same **Accident**, only one benefit is payable. The larger of the Tendons/Ligament/Rotator Cuff Benefit, the **Fracture** benefit or the **Dislocation** benefit will be payable. [In addition, if the **Covered Person** is covered for the Surgical Indemnity Benefit and benefits for either repair or Exploratory Surgery without repair would be covered under the Surgical Indemnity Benefit, the **Covered Person** will be entitled to the larger **Benefit Amount** but not both benefits.]]

**[Torn Knee Cartilage Benefit]**

**We** will pay the **Benefit Amount** as shown in Section II of the Schedule of Benefits if a **Covered Person's Accident** results in a torn knee cartilage (meniscus). The torn knee cartilage (meniscus) must be treated by a **Physician** within [X] days after the **Accident**. It must be repaired through surgery by a **Physician** within six months after the **Accident**. One benefit will be paid for each **Accident**. If exploratory surgery is performed and no repair is done, or if the cartilage is shaved (debridement), **We** will pay the **Benefit Amount** for Exploratory Surgery without repair as shown in Section II of the Schedule of Benefits in lieu of the Torn Knee Cartilage (meniscus) Benefit. [In addition, if the **Covered Person** is covered for the Surgical Indemnity Benefit and benefits for either repair or Exploratory Surgery without repair would be covered under the Surgical Indemnity Benefit, the **Covered Person** will be entitled to the larger **Benefit Amount** but not both benefits.]]

## SECTION II – ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION

### Eligibility

A person is eligible to become an **Insured Person** under this policy if such person is a member of an eligible **Class [I]** of **Covered Persons** as shown in Section I of the Schedule of Benefits.

### Enrollment

An eligible person may enroll for insurance on a written or electronic form provided by or acceptable to **Us**. Such person must enroll within [31] days of when initially eligible or will be considered a late enrollee.

### Effective Date of Insurance for the Insured Person

Insurance for the **Insured Person** becomes effective, subject to payment of any premium due, on the later of:

- 1) the effective date of this policy; or
- 2) the date **We** accept the eligible person's enrollment form.

### [Dependent's Eligibility and Effective Date

An **Insured Person** must be covered in order for him or her to cover the eligible **Dependents**. A **Dependent** is eligible to be covered under the policy when:

- 1) such person is a member of an eligible **Class [II][III]** of **Covered Persons** as shown in Section I of the Schedule of Benefits; and
- 2) such person is enrolled by the **Insured Person** within [31] days of the date he or she is first eligible.

Insurance for the **Dependent Covered Person** becomes effective, subject to payment of the premium due, on the later of:

- 1) the effective date of the **Insured Person's** insurance under this policy; or
- 2) the date on which such **Dependent** first meets the eligibility criteria, is enrolled and is accepted by **Us**.]

### [Late Enrollees

If a person otherwise eligible to enroll for insurance does not enroll within [31] days of when initially eligible, he or she will be considered a late enrollee. He or she may apply for insurance after the period of eligibility expires but any **Pre-existing Condition** will be excluded for the time period described in the **Pre-existing Condition** exclusion. Insurance will become effective on the date **We** approve the enrollment form, subject to timely payment of premium.]

### [Change in Family Status

If a person does not enroll when initially eligible but has a family status change, he or she is not considered a late enrollee if he or she enrolls for coverage and provides proof of the Family Status Change within [ 31] days after the date of change. The qualifying Family Status Changes acceptable to **Us** and the satisfactory proof required for each change are listed below.

<u>Family Status Changes</u>	<u>Acceptable Proof</u>
Birth of a child	Birth certificate
Adoption of a child	Adoption papers
Death of a <b>Spouse [Domestic Partner]</b>	Death certificate
Divorce [Dissolution of Domestic Partnership]	Divorce decree [or proof of dissolution of Domestic Partnership]
Marriage [Domestic Partnership]	Marriage certificate [Affidavit of Domestic Partnership or other registration proof required by law]
<b>Spouse's [Domestic Partner's]</b> loss of a job	Separation papers from <b>Spouse's [Domestic Partner's]</b> employer

]

#### [Newborn Children]

A newborn child born to the **Insured Person** [or the **Insured Person's Spouse**[**Domestic Partner**]] will become insured under this policy automatically from birth as long as the **Insured Person's** coverage was in force on that date. Coverage includes prematurity, congenital defects and birth abnormalities. The newborn child's coverage will not continue past the [thirty-one (31) day] period following birth unless:

- 1) **We** are notified by the end of that [thirty-one (31) day] period of the addition of such newborn child; and
- 2) any applicable additional premium is paid.]

#### [Adopted Children]

An adopted child who has not attained [eighteen (18)] years of age, will become insured under the Policy automatically as of the date of adoption or placement for adoption as long as the **Insured Person's** insurance is in force. Placement for adoption means the assumption and retention by a person of legal obligation for total or partial support of a child in anticipation of the child's adoption. Coverage for an adopted child will not continue past the [thirty-one (31)-day] period following placement unless:

- 1) **We** are notified by the end of the [thirty-one (31)-day] period of the addition of such adopted child; and
- 2) any applicable additional premium is paid.]

#### Termination of Insurance for the Covered Person

Insurance for the **Covered Person** automatically terminates on the earliest of:

- 1) the termination date of this policy;
- 2) the expiration of the period for which required premium has been paid for such **Covered Person**;
- 3) the date on which a person no longer meets the eligibility criteria as a **Covered Person**;
- 4) the date the **Covered Person** requests in writing that coverage be terminated[;] [
- 5) the date on which the **Covered Person** attains age [eighty-five (85)][;] [and
- 6) in addition, for any **Dependent Covered Person**, the date the insurance terminates for the **Insured Person** ] ] .

### SECTION III – GENERAL EXCLUSIONS

The following exclusions apply to all benefits under this policy. Additional exclusions, limitations or conditions may also apply to specific benefits. Please read this entire policy carefully.

#### [Aircraft Pilot or Crew]

This insurance does not apply to any **Accident** caused by or resulting from, directly or indirectly, the **Covered Person** entering, flying or exiting any aircraft while acting or training as a pilot or crew member. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life-threatening emergency. ]

#### [Cosmetic Surgery]

This insurance does not apply to cosmetic surgery or care or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to cosmetic surgery [resulting from an **Accident** if initial treatment of the **Covered Person** is begun within twelve (12) months of the date of the **Accident** or to treat congenital defects in covered newborns.]

#### [Experimental or Investigational]

This insurance does not apply to any service, supply or care that is **Experimental or Investigational**. ]

#### [Extreme Sports]

This insurance does not apply to any **Accident** caused by or resulting from, directly or indirectly, a **Covered Person's** participation in scuba diving to depths of more than 130 feet; skydiving; hang-gliding or para-gliding; parascending other than over water; bungee jumping; mountaineering or rock climbing normally requiring the use of guides or ropes; or caving.]

#### [Illegal Acts]

This insurance does not apply to any [**Accident** or] **Sickness** caused by or resulting from, directly or indirectly, the **Covered Person's** commission or attempted commission of a felony or being engaged in an illegal occupation. ]

#### [Immunizations and Routine Examinations]

This insurance does not apply to immunization shots and routine examinations including: health exams; periodic check-ups; pre-marital exams; and routine physicals, except as otherwise covered under the policy.]

#### [Incarceration]

This insurance does not apply to any [**Accident** or] **Sickness** caused by or resulting from, directly or indirectly any occurrence while the **Covered Person** is incarcerated.]

#### [Infertility and Sex Changes]

This insurance does not apply to sex changes or the reversal of tubal ligation and vasectomies, artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications, or **Physician's** services, unless required by law.]

#### [Intoxication Exclusion]

This insurance does not apply to any **Accident** caused by or resulting from, directly or indirectly, the **Covered Person** being intoxicated, at the time of an **Accident**. Intoxication is defined by the laws of the jurisdiction where such **Accident** occurs. ]

#### [Alcoholism and Drug or Substance Abuse]

This insurance does not apply to alcoholism or drug or substance abuse. In addition, the insurance does not apply to any confinement in a detoxification facility or drug or alcohol rehabilitation facility that is not also a **Hospital** or part of a **Hospital**.]

#### [Intoxication Exclusion Vehicular]

This insurance does not apply to any **Accident** caused by or resulting from, directly or indirectly, the **Covered Person** being intoxicated, while operating a motorized vehicle at the time of an **Accident**. Intoxication is defined by the laws of the jurisdiction where such **Accident** occurs. ]

#### [Narcotic Exclusion]

This insurance does not apply to any [ **Accident** or] **Sickness** caused by or resulting from, directly or indirectly, the **Covered Person** being under the influence of any narcotic or other controlled substance at the time of the loss. This exclusion does not apply if any narcotic or other controlled substance is taken and used as prescribed by a **Physician**. ]

#### [Pre-existing Condition]

This insurance does not pay any benefits for **Sickness** caused by or resulting from a **Covered Person's Pre-existing Condition** if the **Sickness** occurs during the first [1-12] months that a **Covered Person** is insured under this policy. [If the **Covered Person** is a late enrollee, this exclusionary time period is [18] months.]]

#### [Pregnancy]

This insurance does not apply to normal pregnancy. Complications of Pregnancy are covered as any other **Sickness**.]

#### [Pregnancy of a Dependent Child]

This insurance does not apply to pregnancy of a **Dependent Child**, unless required by law.]

#### [Professional Sporting Activity]

This insurance does not apply to any **Accident** caused by or resulting from, directly or indirectly, the **Covered Person** participating in any professional sporting activity for which the **Covered Person** received a salary or prize money. ]

#### [Rest care or custodial care and treatment]

This insurance does not apply to any rest care or custodial care or treatment for any [**Accident** or] **Sickness**.

[Race or Speed Contest]

This insurance does not apply to any **Accident** caused by or resulting from, directly or indirectly, the **Covered Person** being engaged in or participating in a motorized vehicular race or speed contest. ]

[Rocket Propelled or Rocket Launched Conveyance]

This insurance does not apply to any **Accident** caused by or resulting from, directly or indirectly, the **Covered Person** traveling or flying on any rocket propelled or rocket launched conveyance.]

[Service in the Armed Forces]

This insurance does not apply to any [ **Accident** or] **Sickness** caused by or resulting from, directly or indirectly, the **Covered Person** participating in military action while in active military service with the armed forces of any country or established international authority. ]

[Suicide or Intentional Injury]

This insurance does not apply to, and no benefits are payable related to the **Covered Person's** suicide, attempted suicide or intentionally self-inflicted injury.]

Voluntary Abortion

This insurance does not apply to voluntary abortion, except with respect to the **Insured Person** [or his or her covered **[Spouse][Domestic Partner]** where such person's life would be endangered if the fetus were carried to term.

[War]

This insurance does not apply to any [**Accident** or] **Sickness** caused by or resulting from, directly or indirectly, war, undeclared war, civil war, insurrection, rebellion, revolution, warlike acts by a military force or personnel, any action taken in hindering or defending against any of these or any consequences of any of these acts regardless of any other direct or indirect cause or event, whether covered or not, contributing in any sequence to the loss.]

[Well Baby Care]

This insurance does not apply to routine newborn well baby care, including routine nursery charges.]

Workers Compensation

This insurance does not cover [**Accident** or] **Sickness** arising out of and in the course of any occupation for compensation, wage or profit or which are payable under Occupational Disease Law, Workers Compensation or similar law, whether or not application for such benefits have been made.

## SECTION IV – DEFINITIONS

For the purpose of these definitions, the singular includes the plural and the plural includes the singular, unless otherwise noted.

[Accident or Accidental]

**Accident** or **Accidental** means a sudden, unforeseen, and unexpected event which:

- 1) happens by chance;
- 2) arises from a source external to the **Covered Person**;
- 3) is independent of illness, disease or other bodily malfunction or medical or surgical treatment thereof;
- 4) occurs while the **Covered Person** is insured under this policy which is in force; and
- 5) is the direct cause of loss.]

[Advanced Diagnostic Test]

**Advanced Diagnostic Test** means the following tests: Angiogram /Arteriogram, EEG, Myelogram, CT Scan, MRI Scan, and PET Scan.]

Benefit Amount

**Benefit Amount** means the amount stated in the Schedule of Benefits for a benefit covered under this policy for a **Covered Person**.

/Calendar Year

**Calendar Year** means the period of time starting on January 1 and ending on December 31.]

/Chip Fracture

**Chip Fracture** means a small chip of a bone being torn away by the tendon or ligament. It is also known as an avulsion fracture. ]

/Class

**Class** means the categories of **Covered Persons** described in Section I of the Schedule of Benefits.

/Common Carrier

**Common Carrier** means any motorized land, water or air **Conveyance**, organized and licensed for the transportation of passengers for hire and operated by an employee or an individual under contract. ]

/Company

**Company** means Federal Insurance Company.

/Complications of Pregnancy

**Complications of Pregnancy** means conditions which require **Hospital** stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:

- 1) acute nephritis or nephrosis; and
- 2) cardiac decompensation or missed abortion; and
- 3) similar medical and surgical conditions of comparable severity; and
- 4) non-elective caesarean section; and
- 5) termination of an ectopic pregnancy; and
- 6) spontaneous termination when a live birth is not possible. (This does not include elective abortion.).]

/Confined or Confinement

**Confined** or **Confinement** means being admitted to a **Hospital** to receive inpatient services for which the **Covered Person** is charged at least one day's room and board by the **Hospital**. **Confinement** consists of consecutive days of **Confinement** following the date the **Covered Person** is admitted as an inpatient in a **Hospital**. ]

/Conveyance

**Conveyance** means any motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority with competent jurisdiction.]

/Covered Person

**Covered Person** means the **Insured Person** [and his or her insured **Dependents**.]

/Dependent

**Dependent** means a **Dependent Child**, **Spouse** [, or **Domestic Partner**] of an **Insured Person** .]

/Dependent Child

**Dependent Child** means the **Insured Person's** unmarried child from the moment of birth, including a natural child, grandchild, stepchild or adopted child from the date of placement with the **Insured Person** . The **Dependent Child** must be primarily dependent upon such **Insured Person** for maintenance and support, and must be:

- 1) under the age of [nineteen (19)];
- 2) under the age of [twenty-five (25)] if enrolled as a full-time student at an **Institution of Higher Learning**; or
- 3) classified as an **Incapacitated Dependent Child**. ]

/Description of Coverage Year

**Description of Coverage Year** means the consecutive twelve (12) month period starting with the **Insured Person's** effective date of coverage under this policy. Subsequent **Description of Coverage Years** begin on subsequent anniversary years and end 12 consecutive months later.

**[Dislocation]**

**Dislocation** means a completely separated joint.]

**[Domestic Partner]**

**Domestic Partner** means a person designated [at enrollment] by the **Insured Person** who is registered as a **Domestic Partner** or legal equivalent under laws of the governing jurisdiction or who:

- 1) is at least [eighteen (18)] years of age and competent to enter into a contract;
- 2) is not related to the **Insured Person** by blood;
- 3) has exclusively lived with the **Insured Person** for at least [twelve (12) consecutive months] prior to the date of enrollment;
- 4) is not legally married or separated; and
- 5) as of the date of enrollment, has with the **Insured Person** at least two (2) of the following financial arrangements:
  - a) a joint mortgage or lease;
  - b) a joint bank account;
  - c) joint title to or ownership of a motor vehicle or status as a joint lessee on a motor vehicle lease;  
or
  - d) a joint credit card account with a financial institution.

Neither the **Insured Person** nor the **Domestic Partner** can be married to, nor in a civil union with, anyone else. ]

**[Elimination Period]**

**Elimination Period** means the consecutive amount of time, shown in Section II-Benefits of the Schedule of Benefits, that must elapse before a **Benefit Amount** becomes payable. The **Elimination Period** begins on the first day of a **Covered Person's Confinement [In-Hospital][or][in an Intensive Care Unit]**. [**Benefit Amounts** are not payable, nor do they accrue, during an **Elimination Period**.]

**[Emergency Medical Care]**

**Emergency Medical Care** means the sudden onset of a medical condition due to [**Accident** or] **Sickness** for which the **Covered Person** seeks immediate medical care at the nearest available facility. The condition must be one that manifests itself by acute symptoms that are sufficiently severe that, without immediate medical attention, could reasonably be expected to result in:

- 1) placing the **Covered Person's** health in serious jeopardy;
- 2) serious impairment of bodily functions; or
- 3) serious dysfunction of any bodily organ or part.]

**[Experimental or Investigational]**

**Experimental or Investigational** means the service, supply, care or treatment has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication and has not been approved or accepted as essential to the treatment of [ an **Accident** or] **Sickness** by any of the following:

- 1) The American Medical Association
- 2) The United States Surgeon General
- 3) The United States Department of Public Health
- 4) The National Institutes of Health Medicare

**[Fracture]**

**Fracture** means a break in a bone which can be seen by X-ray.]

**[Hemiplegia]**

**Hemiplegia** means complete and irreversible loss of all motion and all practical use of one arm and one leg on the same side of the body that lasts longer than [365 days] as determined by a **Physician** approved by **Us**.]

[Hospital]

**Hospital** means a public or private institution which:

- 1) is licensed in accordance with the laws of the jurisdiction where it is located;
- 2) is accredited by the Joint Commission on Accreditation of Hospitals;
- 3) operates for the reception, care and treatment of sick, ailing or injured persons as in-patients;
- 4) provides organized facilities for diagnosis and medical or surgical treatment;
- 5) provides twenty-four (24) hour nursing care;
- 6) has a **Physician** or staff of **Physicians**; and
- 7) is not primarily a day clinic, rest or convalescent home, assisted living facility or similar establishment and is not, other than incidentally, a place for the treatment of alcoholics or drug addicts.

[**Hospital** includes a **Rehabilitation Facility** [except a facility that is exclusively a treatment facility for alcoholism or drug or substance abuse or a detoxification facility].]

[Immediate Family Member]

**Immediate Family Member** means the **Insured Person's**:

- 1) **Spouse** [or **Domestic Partner**];
- 2) children including adopted children or stepchildren;
- 3) legal guardians or wards;
- 4) siblings or siblings-in-law;
- 5) parents or parents-in-law;
- 6) grandparents or grandchildren;
- 7) aunts or uncles;
- 8) nieces and nephews.

**Immediate Family Member** also means a **Spouse's** [or **Domestic Partner's**] children, including adopted children or stepchildren; legal guardians or wards; siblings or siblings-in-law; parents or parents-in-law; grandparents or grandchildren; aunts or uncles; nieces or nephews.

[Incapacitated Dependent Child]

**Incapacitated Dependent Child** means a child who, as a result of being mentally or physically challenged, is permanently incapable of self-support and permanently dependent on the **Insured Person** for support and maintenance. The incapacity must have occurred while the child was:

- 1) under the age of [nineteen (19)]; or
- 2) under the age of [twenty-five (25)] if enrolled as a full-time student at an **Institution of Higher Learning**. ]

[Institution of Higher Learning]

**Institution of Higher Learning** means any accredited public or private college, university, professional trade or vocational school beyond the twelfth (12) grade.]

[Insured Person]

**Insured Person** means person who is in an eligible **Class** and has a direct relationship with the **Policyholder** who has

- 1) enrolled for insurance under this policy; and
- 2) paid any required premium due for the insurance elected.

[In-Hospital]

**In-Hospital** means registered as an in-patient and **Confined** to a **Hospital** while being treated by a **Physician**. **In-Hospital** does not include confinement solely for convalescent or nursing care. ]



*[Intensive Care Unit]*

**Intensive Care Unit** means only that specifically designated facility of the **Hospital** that provides the highest level of medical care. It is restricted to patients who are critically ill or injured. The **Intensive Care Unit** must be listed in the current edition of the American Associate Guide or eligible to be listed therein. This guide lists three types of facilities that meet the definition of **Intensive Care Unit**:

- 1) **Intensive Care Unit;**
- 2) **Cardiac Intensive Care Unit;** and
- 3) **Infant (neonatal) Intensive Care Unit.** ]

*[Loss]*

**Loss** means **Accidental**:

**Loss of Foot**  
**Loss of Hand**  
**Loss of Hearing**  
**Loss of Life**  
**Loss of Sight**  
**Loss of Sight of One Eye**  
**Quadriplegia**  
**Paraplegia**  
**Hemiplegia**  
**Loss of Speech**  
**Uniplegia**  
**Loss of Thumb and Index Finger**

**Loss** must occur within one (1) year after the **Accident**.]

*[Loss of Foot]*

**Loss of Foot** means the complete severance of a foot through or above the ankle joint. **We** will consider such severance a **Loss of Foot** even if the foot is later reattached. If the reattachment fails and amputation becomes necessary, then **We** will not pay an additional **Benefit Amount** for such amputation.]

*[Loss of Hand]*

**Loss of Hand** means complete severance, as determined by a **Physician**, of at least four (4) fingers at or above the metacarpal phalangeal joint on the same hand or at least three (3) fingers and the thumb on the same hand. **We** will consider such severance a **Loss of Hand** even if the hand, fingers or thumb are later reattached. If the reattachment fails and amputation becomes necessary, then **We** will not pay an additional **Benefit Amount** for such amputation.]

*[Loss of Hearing]*

**Loss of Hearing** means permanent, irrecoverable and total deafness, as determined by a **Physician**, with an auditory threshold of more than 90 decibels in each ear. The deafness cannot be corrected by any aid or device, as determined by a **Physician**.]

*[Loss of Life]*

**Loss of Life** means death, including clinical death, as determined by the local governing medical authority where such death occurs within 365 days after an **Accident**.]

*[Loss of Sight]*

**Loss of Sight** means permanent loss of vision. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a **Physician**.]

*[Loss of Sight of One Eye]*

**Loss of Sight of One Eye** means permanent loss of vision of one eye. Remaining vision in that eye must be no better than 20/200 using a corrective aid or device, as determined by a **Physician**.]

*[Loss of Speech]*

**Loss of Speech** means the permanent, irrecoverable and total loss of the capability of speech without the aid of mechanical devices, as determined by a **Physician**.]

*[Loss of Thumb and Index Finger]*

**Loss of Thumb and Index Finger** means complete severance, through the metacarpal phalangeal joints, of the thumb and index finger of the same hand, as determined by a **Physician**. **We** will consider such severance a **Loss of Thumb and Index Finger** even if a thumb, an index finger or both are later reattached. If the reattachment fails and amputation becomes necessary, then **We** will not pay an additional **Benefit Amount** for such amputation. ]

*[Major Surgical Procedure]*

**Major Surgical Procedure** means a surgical procedure required to treat [an injury caused by an Accident or] a Sickness that requires general anesthesia with respiratory assistance.]

*[Mental Illness]*

**Mental Illness** means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered to a **Covered Person**. [For purposes of this policy, **Mental Illness** does not include alcoholism or drug or substance abuse.]

*[Minor Surgical Procedure]*

**Minor Surgical Procedure** means a surgical procedure required to treat [an injury caused by an Accident or] a Sickness that is not considered a **Major Surgical Procedure**.]

*[Outpatient Unit]*

**Outpatient Unit** means a licensed treatment center that has:

- 1) permanent facilities;
- 2) a **Physician** present during all operating hours; and
- 3) ancillary services, including laboratory and X-ray, staffed during all operating hours. ]

*[Paraplegia]*

**Paraplegia** means complete and irreversible loss of all motion and all practical use of both legs that lasts longer than [365 days], as determined by a **Physician** approved by **Us**.]

*[Period of Confinement]*

**Period of Confinement** means a period of consecutive days of **In-Hospital stay** from the date the **Covered Person** is admitted to the **Hospital** until the date of discharge. The **Period of Confinement** must be for at least one 24 hour period. A **Confinement** for a **Sickness** shall not be combined with another **Confinement** for an **Accident** in determining a **Period of Confinement**.]

*[Physician]*

**Physician** means a licensed practitioner of the healing arts, acting within the scope of his or her license to the extent provided by the laws of the jurisdiction in which medical treatment is provided. **Physician** does not include:

- 1) the **Covered Person**;
- 2) an **Immediate Family Member**;
- 3) the **Covered Person's** employer or business partner; or
- 4) the **Policyholder**].

*[Plan Year]*

**Plan Year** means the twelve (12) month period of time used to determine how benefits are paid. The Plan Year is shown in Section II of the Schedule of Benefits.

*[Policy Period]*

**Policy Period** means the period of time shown in Section II of the Insurance Agreement.

*[Policy Year]*

**Policy Year** means the consecutive twelve (12) months period starting on the Policy Effective Date.]

*Policyholder*

**Policyholder** means the entity identified in the Insuring Agreement.

*[Pre-existing Condition]*

**Preexisting Condition** means [an **Accident** or ] a **Sickness** for which, in the [1-12] months before the **Covered Person** becomes insured under the policy, medical advice, treatment or care was sought by a **Covered Person**, or was recommended by, prescribed by or received from a **Physician**.]

*Proof of Loss*

**Proof of Loss** means written evidence acceptable to Us that [an **Accident**] [or] **Sickness**] has occurred that results in a loss covered under this Policy.

*[Quadriplegia]*

**Quadriplegia** means complete and irreversible loss of all motion and all practical use of both arms and legs that lasts longer than [365 days], as determined by a **Physician** approved by Us.]

*[Rehabilitation Facility]*

**Rehabilitation Facility** means a public or private institution which:

- 1) is licensed in accordance with the laws of the jurisdiction where it is located;
- 2) is accredited by either the Joint Commission on Accreditation of Health Care Organizations or the Commission on the Accreditation of Rehabilitation Facilities;
- 3) operates for the reception, care and treatment of sick, ailing or injured persons as in-patients;
- 4) provides organized facilities for the rehabilitation of physical disabilities;
- 5) provides twenty-four (24) hour nursing care;
- 6) has a **Physician** or staff of **Physicians**; and
- 7) is not primarily a day clinic, rest or convalescent home, assisted living facility or similar establishment and is not, other than incidentally, a place for the treatment of alcoholics or drug addicts.]

*Sickness*

**Sickness** means a physical illness or disease [or **Mental Illness**] that begins while the policy is in force and is not a **Pre-existing Condition**. **Sickness** includes [pregnancy][and] **Complications of Pregnancy**. All **Sicknesses** due to the same or a related cause are considered one **Sickness**.

*[Spouse]*

**Spouse** means the **Insured Person's** husband or wife who is recognized as such by the laws of the jurisdiction in which the **Insured Person** resides. A covered **Spouse** is a **Covered Person**.]

*[Subsidiary]*

**Subsidiary** means any organization in which:

- 1) more than 50% of the outstanding securities or voting rights representing the present right to vote for election of directors is owned or controlled, directly or indirectly, in any combination by the **Policyholder**; or
- 2) the **Policyholder** exercises management control. ]

*[Uniplegia]*

**Uniplegia** means complete and irreversible loss of all motion and all practical use of one arm or one leg that lasts more than [365 days], as determined by a **Physician** approved by Us.]

*We, Us and Our*

**We, Us and Our** means Federal Insurance Company.

## SECTION V – GENERAL PROVISIONS

### Addition of New **Insured Persons**

Any person who newly meets the eligibility criteria for the **Class(es)** described in Section I of the Schedule of Benefits, **Insured Persons** will automatically be eligible for insurance under this policy.

### Assigned Payment of Benefits

An **Insured Person** may assign payment of benefits by notifying **Us** in writing on a form acceptable to **Us** of the assignment. **We** assume no responsibility for the validity or effect of an assignment.

### [Beneficiary

#### A) *Designation*

A **Covered Person** has the right to designate a beneficiary. Notwithstanding, the **Insured Person** shall have the sole right to designate a beneficiary for any **Dependent Child** who is a minor. All beneficiary designations must be:

- 1) in writing;
- 2) filed with the **Policyholder**; and
- 3) provided to **Us** at the time of claim; or
- 4) at such other time as **We** may require.

#### B) *Change*

The **Covered Person** and, no one else, unless there is an irrevocable assignment or such **Covered Person** is a minor or incapable of giving a valid release, has the right to change the beneficiary except as set forth above. The **Covered Person** does not need the consent of anyone to do so. All beneficiary changes must be:

- 1) in writing;
- 2) filed with the **Policyholder**; and
- 3) provided to **Us** at the time of claim or at such other time as **We** may require.

**We** do not assume any responsibility for the validity of these changes.

#### C) *Payment*

The **Benefit Amount** for **Loss of Life** covered under this policy will be paid to the beneficiary designated by a **Covered Person**. Any **Benefit Amount** payable due to the **Loss of Life** of a **Dependent Child** will be paid to the **Insured Person**, absent any beneficiary designation by the **Dependent Child**.

If a **Covered Person** or an **Insured Person** in the case of a minor child or person who is incapable of giving a valid release has not chosen a beneficiary or if there is no beneficiary alive when the **Covered Person** dies, then **We** will pay the **Benefit Amount** for **Loss of Life** to the first surviving party in the following order:

- 1) the **Insured Person's Spouse** [or **Domestic Partner**];
- 2) in equal shares to the **Insured Person's** surviving children;
- 3) in equal shares to the **Insured Person's** surviving parents;
- 4) in equal shares to the **Insured Person's** surviving brothers and sisters;
- 5) the **Insured Person's** estate.

All other **Benefit Amounts** are paid to the **Insured Person**, unless otherwise directed by an **Insured Person** or an **Insured Person's** designee, unless otherwise noted in this policy. If the **Insured Person** is incapable of giving a valid release for benefits payable, **We** will pay benefits to the **Insured Person's** designee or personal representative.

If any beneficiary has not reached the legal age of majority, then **We** will pay such beneficiary's legal guardian.]

### Cancellation, Nonrenewal and Grace Period

#### A) *Grace Period*

The **Policyholder** is entitled to a grace period of [thirty-one (31) days] from the premium due date for the payment of premium due. This policy will continue in force during the grace period. The grace period does not apply to the first

premium payable during this policy term. Failure to pay the first premium on or before the due date will immediately terminate this policy as of inception. **We** are not required to provide notification of such termination.

#### B) Cancellation, Nonrenewal

The **Policyholder** may cancel this policy, or any of its individual insurance benefits, by sending **Us** written notice stating when cancellation is to take effect. The effective date of cancellation may not be earlier than the date notice is postmarked or transmitted.

[The **Insured Person** may cancel his or her insurance described in this policy by returning to **Us** or **Our** authorized representative the Description of Coverage with a written request for cancellation within [ninety (90)] days of receipt. The premium will be fully refunded.]

**We** may cancel this policy, or any of its individual insurance benefits, if the **Policyholder** fails to pay the premium within the grace period of [thirty-one (31) days] after the premium due date, except for the first premium due during the Policy Period. **We** will send written notice stating the effective date of cancellation, which will be no earlier than [thirty-one (31) days] after the premium due date.

**We** may only cancel this policy, or any of its individual insurance benefits, in accordance with applicable law by sending written notice stating when thereafter such cancellation shall take effect.

**We** may non-renew this policy by sending written notice at least [forty-five (45) days] before the expiration date of the Policy Period shown in the Insuring Agreement.

**We** will send notice of cancellation or nonrenewal to the **Policyholder** at its last known address. If the notice is mailed, proof of mailing will be considered proof of cancellation or nonrenewal.

The **Policyholder** is required to immediately provide notice of cancellation or nonrenewal to all **Insured Persons**.

The earned premium will be computed on a [pro-rata] basis. Any unearned premium will be returned to the **Policyholder** as soon as practicable.

#### Changes

This policy can only be changed by a written endorsement that becomes a part of this policy. The endorsement must be approved by one of **Our** officers and signed by one of **Our** authorized representatives. No agent has the authority to change this policy or waive any of its provisions.

#### Compliance by Policyholder and Covered Person

**We** have no duty to provide insurance under this policy unless the **Policyholder**, the **Covered Person** and the beneficiary, if applicable, have fully complied with all the terms and conditions of this policy.

#### Concealment or Fraud

Subject to the "Incontestability" and "Time Limit on Certain Defenses" provisions, insurance under this policy is void if:

- 1) the **Policyholder** or any **Covered Person** has intentionally concealed any material fact or made a material misrepresentation relating to this policy before or after a loss;
- 2) the **Policyholder** or any **Covered Person** has intentionally concealed any material fact or made a material misrepresentation relating to a loss or benefit otherwise payable; or
- 3) the **Policyholder** or any **Covered Person** files a false report of a loss.

#### Conforming to Trade Sanction Laws

This policy does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit **Us** from providing insurance.

#### Claim Notice

Written Claim Notice must be given to **Us** or any of **Our** brokers or appointed agents within twenty (20) days after the occurrence or commencement of any loss covered by this policy or as soon as reasonably possible. Notice must include

enough information to identify the **Covered Person** and **Policyholder**. Failure to give Claim Notice within twenty (20) days will not invalidate or reduce any otherwise valid claim if notice is given as soon as reasonably possible.

#### Claim Forms

When **We** receive notice of a claim, **We** will send the **Covered Person** or the **Covered Person's** designee, within fifteen (15) days, forms for giving **Proof of Loss** to **Us**. If the **Covered Person** or the **Covered Person's** designee does not receive the forms, then the **Covered Person** or the **Covered Person's** designee should send **Us** a written description of the loss. This written description should include information detailing the occurrence, type and extent of the loss for which the claim is made.

#### Claim Proof of Loss

Complete **Proof of Loss** must be given to **Us** within ninety (90) days after the date of the loss, or as soon as reasonably possible.

**We** have a right to examine under oath, as often as **We** may reasonably require, the **Covered Person**, the **Policyholder**, the beneficiary, or the **Covered Person's** authorized representative. **We** may also require the **Covered Person**, the **Policyholder** or the beneficiary to provide a signed description of the circumstances surrounding the loss and their interest in the loss. The **Covered Person**, the **Policyholder** and the beneficiary will also produce all records and documents requested by **Us** and will permit **Us** to make copies of such records or documents.

#### Claim Payment

**We** will pay the **Covered Person**, beneficiary, or the **Covered Person's** assignee the applicable **Benefit Amount** within sixty (60) days after **We** receive complete **Proof of Loss** if the **Covered Person**, the **Policyholder** and beneficiary, where applicable, have complied with all the terms of this policy.

#### Claim and Suit Cooperation

In the event of a claim under this policy, the **Policyholder**, the **Covered Person** or the beneficiary, if applicable, must fully cooperate with **Us** in **Our** handling of the claim, including, but not limited to, the timely submission of all medical and other reports, and full cooperation with all physical examinations and autopsies that **We** may require. If **We** are sued in connection with a claim under this policy, then the **Policyholder**, the **Covered Person** or the beneficiary must fully cooperate with **Us** in the handling of such suit. The **Policyholder**, the **Covered Person** or the beneficiary must not, except at their own expense, voluntarily make any payment or assume any obligation in connection with any suit without **Our** prior written consent.

#### Description of Coverage

When required by law, the **Policyholder** will deliver to the **Insured Person** a Description of Coverage, approved by **Us**. The Description of Coverage will describe the benefits, exclusions, limitations, and conditions of this policy and state to whom benefits are payable. Any subsequent changes to this policy will also apply to the existing Description of Coverage.

#### Entire Contract and Application

This policy, the **Policyholder's** application and the **Insured Person's** enrollment form, if any, together with the endorsements attached to this policy, constitute the entire contract of insurance. If an application is completed by the **Policyholder** in connection with this policy, then **We** will attach the application to the policy when the policy is issued.

#### Governing Jurisdiction and Conformance with Statutes

This policy is governed by the laws of the jurisdiction in which it is delivered to the **Policyholder**. Any terms of this policy which are in conflict with the applicable statutes, laws or regulations of the jurisdiction in which this policy is delivered are amended to conform to such statutes, laws or regulations. Any terms of a Description of Coverage which are in conflict with the applicable statutes, laws or regulations of the jurisdiction in which the Description of Coverage is delivered are amended to conform to the statutes, laws or regulations of the jurisdiction.

#### Informational and Advertising Material

The **Policyholder** and its representatives must gain **Our** prior written approval of all material used for advertising and solicitation relating to this policy, regardless of the medium in which such material appears. **We** will not be responsible for any increase in payment or any changes in insurance resulting from such materials that have not been approved by **Us**.

### Incontestability

The policy will be incontestable, except for non-payment of premium and material fraudulent misstatements, after it has been in force for two years.

### Legal Action Against Us

No legal action may be brought to recover on this policy until sixty (60) days after **We** have been given complete **Proof of Loss**. No such action may be brought after three (3) years from the time complete **Proof of Loss** is required to be given. No such action may be brought unless there has been full compliance with all of the terms of this policy.

In no case will **We** be liable for benefits that are not payable under the terms of this policy or that exceed the applicable **Benefit Amounts** or limits of insurance of this policy.

### Liberalization

If **We** adopt any changes:

- 1) within forty-five (45) days prior to the policy effective date shown in the Insuring Agreement; or
- 2) during the **Policy Period**,

which broaden this insurance without an additional premium charge, then the **Covered Person** will automatically receive the benefit of the broadened insurance.

### Misstatement of Age

If the age of a **Covered Person** has been misstated, **We** will make an equitable adjustment of the premium and benefits. The premium will be the difference between the premiums paid and the premiums that would have been paid at the **Covered Person's** true age. If coverage would not have been provided, **We** will refund the premiums paid for such insurance on and terminate the insurance, if no benefits have been paid. Benefits payable will be based on the correct age and premium paid.

### Newly Acquired or Newly Formed Organizations

If the **Policyholder** acquires or forms another entity that becomes a **Subsidiary**, then at the **Policyholder's** request **We** will enroll all eligible [**Accountholders**] [members] of such **Subsidiary** as soon as possible subject to the following requirements:

- 1) all eligible [employees/members] of such **Subsidiary** fit the **Class** Description shown in Section I of the Schedule of Benefits;
- 2) the **Subsidiary** is acquired or formed during the Policy Period;
- 3) the **Policyholder** reports the name of the **Subsidiary** [within thirty(30) days] after its acquisition or formation together with such information that **We** at **Our** sole discretion may require to determine the additional premium ; and
- 4) the **Policyholder** pays the additional required premium.

[Item three (3) above does not apply to a **Subsidiary** with less than [100] eligible employees unless the number of eligible employees for such **Subsidiary** exceeds [ten percent (10%)] of the insured group]

This insurance does not apply if the **Policyholder** advises **Us** in writing that it does not seek insurance under this policy for such newly acquired or formed **Subsidiary**.

### Physical Examination and Autopsy

**We** have the right to have the **Covered Person** examined by a **Physician** approved by **Us**, as often as reasonably necessary while a claim is open. **We** may also have an autopsy done by a **Physician**, unless prohibited by law. Any examinations or autopsies that **We** require will be done at **Our** expense.

### Premium Payment

The **Policyholder** or **Our** designated administrator will collect and remit to **Us** all premiums due under this policy, subject to the grace period.

### Premium Rate Change

We may change the premium rates for this policy subject to **Our** providing the **Policyholder** with at least [one hundred and eighty (180)] days prior written notice of such change.

#### [Rate Guarantee]

The premium rate is guaranteed until [01/01/13]. We reserve the right, during the guaranteed rate period, to change the premium rate if one of the following occurs:

- 1) a change in the insurance provided under this policy;
- 2) a division, **Subsidiary** or affiliated company of the **Policyholder** is added or deleted;
- 3) the number of **Insured Persons** changes by [25% ]or more;
- 4) a new law or change to any existing law is enacted which affects the insurance provided under this policy; or
- 5) any other material change in the risk insured.

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#### Records and Audit

We may examine the **Policyholder's** books and records relating to this policy at any reasonable time during the policy term and up to three (3) years after expiration of this policy or until final adjustment and settlement of all claims under this policy, whichever is later.

The **Policyholder** must maintain information pertaining to **Covered Persons** including but not limited to each **Covered Person's Benefit Amount, Class, [salary,]enrollment form, if any, and beneficiary designations or assignments.**

#### Replacement Insurance

If this policy is replacing another policy of similar insurance, the **Policyholder** will be responsible for notifying all **Insured Persons** of the change in insurance carriers and the change in insurance coverage, if any, by providing a description of coverage approved by Us.

If a **Covered Person** was covered under the **Prior Carrier's** plan for [Accident and] Sickness **Hospital** Indemnity insurance on the day prior to this policy's effective date, then such person will become a **Covered Person** under this policy on the Policy Effective Date when:

- 1) this policy is entered into within 31 days of the termination of the **Prior Carrier's** policy and insures some or all of the same group that was insured under the **Prior Carrier's** policy;
- 2) the insurance on the **Covered Person** under the **Prior Carrier's** policy terminated solely by reason of termination of such policy; and
- 3) such person is a member of an eligible **Class**.

We will adjust the time limits described in the provisions entitled "Incontestability" and "Time Limit on Certain Defenses" and the Pre-existing Conditions exclusion by giving the **Covered Person** credit for satisfaction or partial satisfaction of the comparable provisions under the **Prior Carrier's** policy.

In no event, will any loss be covered under this Policy if it is paid or payable under the **Prior Policy** or paid or payable under a settlement by the **Prior Carrier** related to coverage under the **Prior Carrier's** policy.

If such person desires an increased **Benefit Amount**, then such person must enroll for the increased **Benefit Amount** . The amount by which the increased **Benefit Amount** exceeds the replaced **Benefit Amount** will be subject to a new "Time Limit on Certain Defenses" and Pre-existing Conditions exclusion.

For purposes of this provision, **Prior Carrier** means the insurance carrier that provided Sickness **Hospital** Indemnity Insurance to the **Covered Persons** of the prior **Policyholder** shown in Section II of the Insuring Agreement on the day immediately preceding the policy effective date for this policy.

#### Time Limit on Certain Defenses

In the absence of fraud, statements made by a **Covered Person** are deemed representations and not warranties. After two years from the **Covered Person's** effective date of coverage, no misstatements, except fraudulent misstatements, on the **Covered Person's** enrollment form may be used to:

- 1) void this coverage; or
- 2) deny or reduce any claim for loss that occurs after the two year period.



If a **Covered Person** receives an increase in any **Benefit Amount**, an additional two year time limit period will apply to the increase in benefits only.

Titles of Paragraphs

The titles of the various paragraphs of this policy and any endorsements attached to this policy are inserted solely for convenience of reference and do not limit or affect in any way the provisions to which they relate.

Workers' Compensation

The benefits payable under this policy are not in lieu of and do not affect any requirement for workers' compensation insurance.

**Hospital Indemnity Policy Acceptance**

**[Policyholder Name and Address]**

On behalf of the **Policyholder**, I do hereby accept Policy number: \_\_\_\_\_

Issued by Federal Insurance Company

Name of Policyholder:\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

Date\_\_\_\_\_



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**Endorsement****Arkansas Amendatory**

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**Effective Date:** [01-01-13]  
**Policy Number:** [1234-56-7890]  
**Policyholder:** [ABC, Inc.]  
**Policy Period:** [01-01-13 to 01-01-14}  
**Name of Company:** [Federal Insurance Company]  
**Issue Date:** [01-01-13]

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It is agreed that the Policy is amended as follows:

Under CONTRACT SECTION II - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION, the following provisions are added:

**Newborn Child Coverage**

A child of an **Insured Person** born while coverage under the policy is in force, is covered from the moment of birth. A notice of birth, together with the additional premium, must be submitted to **Us** within 90 days of birth or before the next premium due date, whichever is later, in order to continue coverage.

**Adopted Child Coverage**

A minor child who comes under the charge, care and control of an **Insured Person** while coverage under the policy is in force, is covered provided the **Insured Person** files a petition to adopt. The coverage of such child will be the same as provided for other members of the **Insured Person's** family. Such child will be covered from the date the petition to adopt is filed if the **Insured Person** applies for coverage and pays any required premium within 60 days after filing the petition to adopt. However, coverage will begin at the moment of birth if the petition for adoption is filed within 60 days after the child's birth. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied. Coverage will continue unless the child's placement is disrupted prior to legal obligation.

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All other terms and conditions of the policy remain unchanged.

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Authorized Representative

# [Accident and] Sickness Limited Benefit Cash Insurance

Underwritten by:

Federal Insurance Company,  
a member insurer of the Chubb Group of  
Insurance Companies  
15 Mountain View Road, PO Box 1615  
Warren, NJ 07061-1615

Administered by:

[Insert  
Contact Info  
Here]

## **Important Notice - Please Read this Description of Coverage Carefully**

As a handy reference guide, please read this document and keep it in a safe place with Your other insurance documents. This description of coverage is not a contract of insurance but is a summary of the principal provisions of the insurance while in effect. Complete provisions are contained in the Policy form [XXXX], which can be obtained from the [Policyholder][Policy Administrator].

POLICYHOLDER: [ABC, INC.]

GROUP POLICY NO.: [1234-56-78]

CLASS DESCRIPTION: [ ]

## **WHEN DOES MY COVERAGE BECOME EFFECTIVE?**

Subject to payment of premium due, Your insurance becomes effective on the later of the following: 1) on the date the policy is effective which is [January 1, 2013]; or 2) when We accept the eligible person's enrollment form.

## **[WHEN DOES MY DEPENDENT'S COVERAGE BECOME EFFECTIVE?**

If You want to cover an eligible Dependent per the Class Description above, he or she will become a Covered Person on the later of the following: 1) the effective Date of Your insurance under this policy, subject to payment of any premium due; or 2) the date You enroll the Dependent for insurance and pay the premium due.]

## **WHEN DOES COVERAGE TERMINATE?**

Insurance for a Covered Person automatically terminates on the earliest of: 1) the termination date of this policy; 2) the expiration of the period for which required premium has been paid for such Covered Person; 3) the date on which a person no longer meets the eligibility criteria as a Covered Person; 4) the date the Covered Person requests in writing that coverage be terminated. [;] 5) [the date on which the Covered Person attains age [eighty-five (85)][;] [or] 6) [for any Dependent Covered Person, the date Your insurance terminates.]

## **[IF I DO NOT ENROLL WHEN INITIALLY ELIGIBLE, MAY I ENROLL LATER?**

Yes, if a person otherwise eligible to enroll for insurance does not enroll when initially eligible, he or she will be considered a late enrollee. He or she may apply for insurance after the period of eligibility expires but any Pre-existing Condition will be excluded for the time period described in the Pre-existing Condition exclusion for a late enrollee. Insurance will become effective on the date We approve the enrollment, subject to timely payment of premium.]

**[IF I DO NOT ENROLL WHEN INITIALLY ELIGIBLE BUT HAVE A CHANGE IN FAMILY STATUS, MAY I ENROLL LATER?**

Yes, if a person does not enroll when initially eligible but has a family status change, he or she is not considered a late enrollee if he or she enrolls for coverage and provides proof of the Family Status Change within [31] days after the date of change. The qualifying Family Status Changes acceptable to Us and the satisfactory proof required for each change are listed below.

Family Status Changes	Acceptable Proof
Birth of a child	Birth certificate
Adoption of a child	Adoption papers
Death of a Spouse [Domestic Partner]	Death certificate
Divorce [Dissolution of Domestic Partnership]	Divorce decree [or proof of dissolution of Domestic Partnership]
Marriage [Domestic Partnership]	Marriage certificate [Affidavit of Domestic Partnership or other registration proof required by law]
Spouse's [Domestic Partner's] loss of a job	Separation papers from Spouse's [Domestic Partner's] employer

]

**[HOW DO I ADD NEWBORN CHILDREN AND ADOPTED CHILDREN IF I AM ALREADY COVERED?**

Newborn Children: A child of Yours born while coverage under the policy is in force, is covered from the moment of birth. A notice of birth, together with the additional premium, must be submitted to Us within 90 days of birth or before the next premium due date, whichever is later, in order to continue coverage.

Adopted Children: A minor child who comes under Your charge, care and control while coverage under the policy is in force, is covered provided You file a petition to adopt. The coverage of such child will be the same as provided for other members of the Your family. Such child will be covered from the date the petition to adopt is filed if You apply for coverage and pay any required premium within 60 days after filing the petition to adopt. However, coverage will begin at the moment of birth if the petition for adoption is filed within 60 days after the child's birth. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied. Coverage will continue unless the child's placement is disrupted prior to legal obligation. ]

## WHAT BENEFITS ARE INCLUDED?

Benefits are provided [worldwide][in the United States including its territories and jurisdictions.]

Benefits are payable based on the Plan Year as follows: [Calendar Year][Policy Year][Description of Coverage Year]

The following benefits are included in Your coverage. Please note that Your covered Spouse [or covered Domestic Partner] or Your Covered Dependent Child's benefits are not payable at the same level as Your benefits.

[The covered Spouse [or covered Domestic Partner] is paid at [50%-100%] of Your Benefit Amount listed below for any loss covered under this policy. ]

[The covered Dependent Child is paid at [10-100%] of Your Benefit Amount listed below for any loss covered under this policy. ]

## [ HOSPITAL ADMISSION INDEMNITY BENEFIT

### What Is This Benefit?

We will pay a Hospital Admission Benefit if a Covered Person is admitted to a Hospital and Confined due to Sickness [or as the result of an Accident]. [The Covered Person must become Confined within [6] months after the covered Accident]. No benefit will be paid for:

- 1) [emergency room treatment;]
- 2) [outpatient treatment]; [or]
- 3) [a stay of less than 20 hours in an observation unit.]

The Benefit Amount is shown below.

[We will not pay more than the Maximum number of admissions as shown below.]]

### How much insurance is provided?

Benefit Amount per Hospital admission: [\$XXX]

[Maximum number of admissions [per] [Sickness][or][Accident] [per Plan Year]: [X]]

## [ IN-HOSPITAL INDEMNITY BENEFIT

### What Is This Benefit?

We will pay the daily In-Hospital Benefit Amount [after the Elimination Period] shown below, for each day a Covered Person is In-Hospital due to a Sickness [or Accident]. [The first day of a Hospital stay must occur within [thirty (30)] days of the Accident, causing the Injury.]

The In-Hospital Benefit Amount will be paid until the earliest of the date the:

- 1) Covered Person dies;
- 2) Covered Person is no longer In-Hospital; or
- 3) Maximum Number of Days, shown below, has elapsed; or
- 4) Maximum Benefit Amount has been paid.

[A Confinement for a Sickness shall not be combined with another Confinement for an Accident in determining a Period of Confinement.]

[Retroactive Benefit: If a Covered Person is Confined In-Hospital [or in an Intensive Care Unit] for treatment of Sickness [or Accident] after the Elimination Period, We will pay the daily Benefit Amount retroactively to the first day of In-Hospital [or Intensive Care Unit Confinement.]

[We will not pay more than the Maximum Benefit Amount, shown below.]]

**How much insurance is provided?**

Daily Benefit Amount: [\$300]

[Elimination Period for Sickness:[0-7 days]]

[Elimination Period for Accident:[0-7 days]]

[Retroactive Benefit: ☐ yes ☐ no]

Maximum Number of Days per [Period of Confinement] [Sickness [or Accident] [per Plan Year]: [90]

[Maximum Benefit Amount per [Sickness ][and Accident combined] [per Plan Year]:  
[\$100,000]]

**What Special Conditions Apply To This Benefit?**

[If a Covered Person is initially Confined in a Hospital, before benefits are payable under the policy, the Covered Person must satisfy the Elimination Period which means that the Covered Person must be Confined in a Hospital for the number of consecutive days shown above. [If the Period of Confinement starts with Intensive Care Unit Confinement and the Covered Person has satisfied the Elimination Period and then is moved to a regular Hospital room, then no additional Elimination Period must be satisfied. If the Period of Confinement starts with Intensive Care Unit Confinement and the Covered Person has not satisfied the Elimination Period and then is moved to a regular Hospital room the Elimination Period must be satisfied taking into account both In-Hospital and Intensive Care Unit Confinements. ]

If a Covered Person is discharged from the Hospital and a different Sickness [or Accident] causes such Covered Person to be In-Hospital again after [1day] of non-confinement, then We will consider it a new Period of Confinement. If a Covered Person is discharged from the Hospital and readmitted for the same [Sickness] [or Accident] as the prior Period of Confinement within [180 days] of the prior Period of Confinement's discharge, it will be considered the same Period of Confinement. If it is considered the same Period of Confinement then a Covered Person will not have to satisfy a new Elimination Period but is subject to the same Maximum Number of Days and any Maximum Benefit Amounts shown above for that[ Sickness] [or Accident]. If it is considered a new Period of Confinement, then a new Elimination Period must be satisfied but the Covered Person is entitled to a new Maximum Benefit Amount.

## [ **RECUPERATION INDEMNITY BENEFIT**

### **What Is This Benefit?**

We will pay the daily Recuperation Benefit Amount shown below once the Covered Person has been discharged from the Hospital if:

- 1) a Sickness [or Accident] causes a Covered Person to be In-Hospital Confined; and
- 2) such Covered Person received a benefit under the In-Hospital Benefit of this policy.

The Recuperation Benefit Amount will be paid for the same number of days for which We paid the In-Hospital Benefit and will be paid in one lump sum after the Covered Person's discharge from the Hospital. If the Covered Person dies while In-Hospital, no Recuperation Benefit is payable.

[We will not pay more than the Maximum Benefit Amount, shown below.]]

### **How much insurance is provided?**

Daily Benefit Amount: [\$100]

[Maximum Benefit Amount per Plan Year:]: [\$100,000] ]

## [ **INTENSIVE CARE UNIT INDEMNITY BENEFIT**

### **What Is This Benefit?**

We will pay the daily Intensive Care Unit Benefit Amount [after the Elimination Period both] shown below, for each day of Confinement if [an Accident or] Sickness causes a Covered Person to be Confined in an Intensive Care Unit. This benefit is paid in addition to the In-Hospital



Benefit Amount]. [The first day of Confinement in the Intensive Care Unit must occur within [thirty (30)] days of the Accident.]

The Intensive Care Unit Benefit Amount will be paid until the earliest of the date:

- 1) the Covered Person dies;
- 2) the Covered Person is no longer Confined in an Intensive Care Unit; or
- 3) the Maximum Number of Days, shown below, has elapsed.

[Retroactive Benefit: If a Covered Person is Confined in an Intensive Care Unit [or In-Hospital] for treatment of Sickness [or Accident] after the Elimination Period, We will pay the daily Benefit Amount retroactively to the first day of [In-Hospital or] Intensive Care Unit Confinement.]

[We will not pay more than the Maximum Benefit Amount, shown below.]]

**How much insurance is provided?**

Daily Benefit Amount: [\$600]

[Elimination Period for Sickness:[0-7 days]]

[Elimination Period for Accident:[0-7 days]]

[Retroactive Benefit: ☐ yes ☐ no]

Maximum Number of Days per [Period of Confinement] [ Sickness [or Accident] [per Plan Year]: [90]

[Maximum Benefit Amount [per Sickness] [and Accident combined] [per Plan Year]: [\$200,000]]

**What Special Conditions Apply To This Benefit?**

[If a Covered Person is initially Confined in an Intensive Care Unit, before benefits are payable under the policy, the Covered Person must satisfy the Elimination Period which means that the Covered Person must be Confined in an Intensive Care Unit for the number of consecutive days shown above. If the Period of Confinement starts with In-Hospital Confinement and the Covered Person has satisfied the Elimination Period and then is moved to the Intensive Care Unit, no additional Elimination Period must be satisfied. If the Period of Confinement starts with In-Hospital Confinement and the Covered Person has not satisfied the Elimination Period and then is moved to the Intensive Care Unit, the Elimination Period must be satisfied taking into account both In-Hospital and Intensive Care Unit Confinements. ]

The Intensive Care Unit Benefit Amount will be paid until the earliest of the date:

- 1) the Covered Person dies;
- 2) the Covered Person is no longer Confined in an Intensive Care Unit; or
- 3) the Maximum Number of Days, shown above has elapsed.

[A Confinement for a Sickness in an Intensive Care Unit shall not be combined with another Confinement in an Intensive Care Unit for an Accident in determining a Period of Confinement.]

If a Covered Person is discharged from the Hospital and a different Sickness [or Accident] causes such Covered Person to be Confined in an Intensive Care Unit again after [1day] of non-confinement, then We will consider it to be a new Period of Confinement. If a Covered Person is discharged from the Hospital and readmitted to an Intensive Care Unit for the same [Sickness] [or Accident] as the prior Period of Confinement within [180 days] of the prior Period of Confinement's discharge, it will be considered the same Period of Confinement. If it is considered the same Period of Confinement then a Covered Person will not have to satisfy a new Elimination Period but is subject to the same Maximum Number of Days and any Maximum Benefit Amounts shown above for that [Sickness] [or Accident]. If it is considered a new Period of Confinement, then a new Elimination Period must be satisfied but the Covered Person is entitled to a new Maximum Benefit Amount.

]

## [ **IN-HOSPITAL PHYSICIAN VISIT INDEMNITY BENEFIT**

### **What Is This Benefit?**

We will pay the In-Hospital Physician Visit Indemnity Benefit Amount, as shown below, for a visit by a Physician during a Period of Confinement in a Hospital as a result of [an Accident or] Sickness. It is not payable for a surgeon's visit in a Hospital following a Major or Minor Surgical Procedure.

[We will not pay more than the Maximum Benefit Amount, shown in below.]]

### **How much insurance is provided?**

Per Visit Benefit Amount: [\$XX]

Maximum Number of visits per Period of Confinement [regardless of the number of visiting Physicians]: [X] ]

## [ **PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT**

### **What Is This Benefit?**

We will pay the Physician Office Visit Indemnity Benefit Amount, as shown below, for a Physician office visit as a result of [an Accident or] Sickness. The visit must be made to the

Physician's office or clinic. [The visit to a Physician's office must occur within [thirty (30)] days of the Accident, causing an Injury.]

Benefits are not payable for:

- 1) visits made by a Physician while the Covered Person is Confined in a Hospital;
- 2) routine eye examinations, or fitting of glasses or fitting of hearing aids;
- 3) dental examinations or dental care [other than expenses resulting from Accidental injury]; or
- 4) Annual physicals, school sports physicals, and other types of preventive visits not required due to [an Accident or] Sickness.

[We will not pay more than the Maximum Benefit Amount, shown below. ]]

**How much insurance is provided?**

Per Visit Benefit Amount: [\$XX]

Maximum number of visits [per] [Sickness][or][Accident] [per Plan Year]: [X] ]

[ **EMERGENCY ROOM INDEMNITY BENEFIT**

**What Is This Benefit?**

We will pay the Emergency Room Benefit Amount, shown below, if an [Accident or] Sickness causes the Covered Person to require and receive Emergency Medical Care in an emergency room of a Hospital. [Treatment must be received within [24] hours of the Accident. ]

[We will not pay more than the Maximum Benefit Amount shown below. ]]

**How much insurance is provided?**

Per Visit Benefit Amount: [\$xx]

Maximum number of emergency room visits [per] [Sickness][or][Accident] [Plan Year]: [X] ]

[ **SURGICAL INDEMNITY BENEFIT**

**What Is This Benefit?**

We will pay the Surgical Indemnity Benefit if a Covered Person has a Major or Minor Surgical Procedure performed [while In-Hospital] [or] [on an outpatient basis in an Outpatient Unit]. The Benefit Amounts are shown below.

If two or more procedures are performed through the same incision or operative field, payment will be made only for the procedure of the larger benefit. If more than one procedure is performed but each through separate incisions or in a separate operative field, the amount payable shall be the specified amount for the primary procedure plus 50% of the amount payable for all other surgical procedures performed.

[A surgical procedure due to Accident must occur within [thirty (30)] days of the Accident, causing an Injury. [If the Major or Minor Surgical Procedure is required for Exploratory Surgery and also payable under the Tendon(s) / Ligament(s) / Rotator Cuff(s) Benefit, We will pay only one benefit. That benefit will be the larger of the Surgical Indemnity Benefit and the Tendon(s) / Ligament(s) / Rotator Cuff(s) Benefit. ]]

We will not pay more than the maximum number of Major or Minor Surgical Procedures in a Plan Year as shown below.]

How much insurance is provided?

[Benefit Amount per In-Hospital Major Surgical Procedure per Covered Person per Plan Year: [\$500-\$10,000]]

[Benefit Amount per Major Surgical Procedure performed in an Outpatient Unit per Covered Person per Plan Year: [\$500-\$5,000]]

[Benefit Amount per In-Hospital Minor Surgical Procedure per Covered Person per Plan Year: [\$100-\$500]]

[Benefit Amount per Minor Surgical Procedure performed in an Outpatient Unit per Covered Person per Plan Year: [\$100-\$500]]

[Maximum Number of In-Hospital Procedures per Covered Person per Plan Year regardless of whether a Major or Minor Surgical Procedure: [1-10]]

[Maximum Number of Outpatient Unit Procedures per Covered Person per Plan Year regardless of whether a Major or Minor Surgical Procedure:[1-10]] ]

## [ **ANESTHESIA INDEMNITY BENEFIT**

### **What Is This Benefit?**

We will pay the Anesthesia Indemnity Benefit for the administration of anesthesia related to a covered surgical procedure, if the Surgical Indemnity Benefit is payable. The Benefit Amount is shown below.

[We will not pay more than the Maximum Benefit Amount, shown below.]]

**How much insurance is provided?**

Benefit Amount per covered Major Surgical Procedure per Covered Person: [\$100 - \$2,000 ]

Benefit Amount per covered Minor Surgical Procedure per Covered Person: [\$0-\$200]

[ **GROUND AMBULANCE TRANSPORTATION INDEMNITY BENEFIT**

**What Is This Benefit?**

If a Covered Person requires the use of an ambulance service by ground for transportation to or from a Hospital or from one Hospital to another Hospital for care and treatment of [an Accident or] Sickness, We will pay the Ground Ambulance Transportation Benefit Amount shown below. [We will not pay more than the Maximum Benefit Amount shown below.

[We will not pay more than the maximum number of trips shown below in a Plan Year.]]

**How much insurance is provided?**

Per trip Benefit Amount: [\$XX]

Maximum number of ground ambulance trips per [Sickness][and][Accident] [per Plan Year] [x]  
]

[ **AIR AMBULANCE TRANSPORTATION INDEMNITY BENEFIT**

**What Is This Benefit?**

If a Covered Person requires the use of an ambulance service by air for transportation to or from a Hospital or from one Hospital to another Hospital for care and treatment of [an Accident or] Sickness We will pay the Air Ambulance Transportation Benefit Amount shown below.

[We will not pay more than the maximum number of trips shown below in a Plan Year.]]

**How much insurance is provided?**

Per trip Benefit Amount: [\$XX]

Maximum number of air ambulance trips per [Sickness][and][Accident] [ per Plan Year]: [X] ]

[ **DIAGNOSTIC X-RAY AND LABORATORY INDEMNITY BENEFIT**

**What Is This Benefit?**

We will pay the Diagnostic X-Ray and Laboratory Indemnity Benefit, as shown below, when a Covered Person has diagnostic x-ray and laboratory tests performed. Such tests and diagnostic x-rays must be ordered by a Physician and be related to [an Accident or] Sickness. This insurance does not pay for x-rays or laboratory tests performed while Confined in a Hospital. In addition, if a test is payable under the Advanced Diagnostic Test Indemnity Benefit, it will be paid under that Benefit and not this Benefit. [Preventive tests are payable under the Wellness Indemnity Benefit and not payable under this Benefit.]

[A diagnostic x-ray and laboratory tests performed due to Accident must be done within [thirty (30)] days of the Accident, causing an Injury.]

[We will not pay more than the number of tests shown in Section II of the Schedule of Benefits in a Plan Year.]]

**How much insurance is provided?**

Benefit Amount per x-ray or test per Covered Person: [\$10-\$100]

Maximum number of X-rays and tests per Covered Person per Plan Year [1-6] ]

[ **ADVANCED DIAGNOSTIC TEST INDEMNITY BENEFIT**

**What Is This Benefit?**

We will pay the Advanced Diagnostic Test Indemnity Benefit, as shown below, when a Covered Person has one of the following tests performed: Angiogram /Arteriogram, EEG, Myelogram, CT Scan, MRI Scan, or PET Scan Such tests must be ordered by a Physician and be related to [an Accident or] Sickness. This insurance does not pay for tests performed while Confined in a Hospital.

[We will not pay more than the number of tests shown below in a Plan Year.]]

**How much insurance is provided?**

Per test per Covered Person per Plan Year: [\$xxxx]

Number of tests per Covered Person per Plan Year: [ XX] ]

[ **PATIENT COMFORT EXPENSE BENEFIT**

**What Is This Benefit?**

We will pay the Covered Person for Patient Comfort Expenses if a Covered Person is Hospital Confined due to Sickness [or Accident] and requires a Hospital stay for more than [one (1) day[s]]. This benefit is only payable if a Covered Person is In-Hospital or Confined in an Intensive Care Unit for which a daily benefit is payable.

In addition to any Proof of Loss required under the Claim Proof of Loss provision, We will require receipts for any covered purchase. Receipts are not required for purchases under \$25.

[We will not pay more than the Maximum Benefit Amount for any Period of Confinement, shown below.]

Patient Comfort Expenses means:

- 1) [the charge for television, internet, pay-per-view, or other pay media services including internet streaming services not necessarily being charged by the Hospital;]
- 2) [the cost of books, magazines, or newspapers for use by the Confined Covered Person;]
- 3) [the cost of electronic media consumption devices such as E-Readers, tablets, MP3, or MP4 players for use by the Confined Covered Person. Electronic media consumption devices does not include cell phones or laptop computers;]
- 4) [charges for phone bills charged by the Hospital to the Covered Person;]
- 5) [any upgrades to meal plans offered by the Hospital that are available for purchase.]]

### **How much insurance is provided?**

Maximum Benefit Amount per Period of Confinement for all Patient Comfort Expenses :[\$XX]

## **[ PET CARE BENEFIT**

### **What Is This Benefit?**

We will pay a benefit for pet care if:

- 1) a Covered Person is Hospital Confined due to Sickness [or Accident]; and
- 2) requires a Hospital stay for more than [one (1) day[s]; and
- 3) owns a house pet that needs professional care for which a charge is made while he or she is Hospital Confined.

We will pay the expense incurred for daily pet care for each day that the Covered Person is Hospital Confined up to the Benefit Amount as shown below. This benefit is only payable if a Covered Person is In-Hospital or confined in an Intensive Care Unit for which a daily benefit is payable. In addition to any Proof of Loss required under the Claim Proof of Loss provision, We will require receipts for any cost of care. Receipts are not required for daily care under \$25.

[We will not pay more than the Maximum Benefit Amount for any one period of In-Hospital Confinement, shown below.]]

### **How much insurance is provided?**

Benefit Amount per day of In-Hospital: [\$xx]

Maximum Benefit Amount per Period of Confinement: [\$XX] ]

## **[ IMMEDIATE FAMILY MEMBER TRAVEL EXPENSE BENEFIT**

### **What Is This Benefit?**

If the Covered Person's Sickness [or Accident] requires a Hospital stay for more than the number of days shown below, then We will reimburse up to the daily Benefit Amount for each Immediate Family Member up to the daily Benefit Amount for Immediate Family Member Travel Expense for each Immediate Family Member up to the maximum number of Immediate Family Members shown below, if all the following conditions are met:

- 1) the Covered Person is confined to a Hospital; and
- 2) the Hospital is at least the number of miles shown below from the Immediate Family Member's primary residence;

The daily Benefit Amount is shown below. We will not pay more than the maximum number of days shown below per Immediate Family Member.

Immediate Family Member Travel Expenses means the cost of a Common Carrier fare, lodging, and food.

In addition to any Proof of Loss required under the Claim Proof of Loss provision, We will require receipts for any Immediate Family Member Travel Expenses. Receipts are not required for travel expenses under \$25.

### **How much insurance is provided?**

Number of Days of consecutive In-Hospital before Benefit Amount payable: [3]

#### Traveling Expenses:

Daily Benefit Amount: [\$xx]



Maximum Number of Days per Immediate Family Member:[x] [x]  
Maximum number of Immediate Family Members: [X]  
Number of Miles between primary residence and Hospital: [X] ]

## [ **LOSS OF INCOME BENEFIT**

### **What Is This Benefit?**

We will pay the daily Loss of Income Benefit Amount to each parent, [Spouse][Domestic Partner] of a Covered Person up to the maximum number of days for Loss of Income shown below. The Loss of Income benefit shall only be provided if:

- 1) the Covered Person is In-Hospital for which a daily benefit is payable under this policy.
- 2) the parent [Spouse][Domestic Partner] of a Covered Person is gainfully employed during the time that the Covered Person remains In-Hospital;
- 3) the parent's [Spouse's][Domestic Partner's] time off is deducted from his or her daily salary or wages;
- 4) the daily Loss of Income Benefit Amount for such parent, [Spouse][Domestic Partner] doesn't exceed the daily salary or wages for such parent, [Spouse] [Domestic Partner]. If the daily Benefit Amount for Loss of Income exceeds the daily salary or wages for such parent, [Spouse][Domestic Partner], We will only pay up to the amount that would have been paid by his or her employer.]

In addition to any Proof of Loss required under the Claim Proof of Loss provision, We will require:

- 1) written proof from the parent's, [Spouse's][Domestic Partner's] employer that the time off was deducted from the daily salary or wage; and
- 2) written proof of the daily salary or wages lost by the parent, [Spouse] [Domestic Partner]

### **How much insurance is provided?**

Benefit Amount per day of In-Hospital regardless of number of parents: [\$xx]

Maximum Number of Days per In-Hospital: [x] ]

## [ **WELLNESS INDEMNITY BENEFIT**

### **What Is This Benefit?**

We will pay this benefit if You [or Your covered [Spouse][or Domestic Partner]] has one of the following screening tests performed while coverage under the Policy which is in force. We will

pay the Benefit Amount shown below. This benefit is payable once per Plan Year for You [or for Your covered [Spouse][or Domestic Partner]. If the benefit is be payable under the Diagnostic X-Ray and Laboratory Indemnity Benefit or the Surgical Indemnity Benefits as it relates to [an Accident or] Sickness, it will be paid under that benefit and not this Wellness Indemnity Benefit.

Screening test is defined as:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (cancer antigen 15-3 - blood test for breast cancer)
- CA125 (cancer antigen 125 - blood test for ovarian cancer)
- CEA (carcinoembryonic antigen - blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum Protein Electrophoresis (blood test for myeloma)
- Thermography
- ThinPrep Pap Test
- Virtual Colonoscopy ]

#### **How much insurance is provided?**

One preventive screening test per Covered Person per Plan Year: [\$25-200]]

### **ADDITIONAL ACCIDENT BENEFITS**

#### **[ ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

#### **What Is This Benefit?**

We will pay the applicable Benefit Amount, shown below, if an Accident results in a Loss covered under this policy and not otherwise excluded. The Accident must occur while a Covered Person is insured under this policy, while it is in force. The Loss must occur within one (1) year after the Accident.]

### **How much insurance is provided?**

[Class] [1]    Loss of Life Benefit Amount: [\$200,000]

[Class] [2]    Loss of Life Benefit Amount: [50% of the Class 1 Your Loss of Life Benefit Amount]

[Class] [3]    Loss of Life Benefit Amount: [15% of the Class 1 Your Loss of Life Benefit Amount]

The following are Losses insured and the corresponding Benefit Amounts expressed as a percentage of the Loss of Life Benefit Amount:

Accidental: Loss of Life	Percent of Loss of Life Benefit Amount [100%]
Loss of Speech and Loss of Hearing	[100%]
Loss of Speech and Loss of one of: Hand, Foot or Sight of an Eye	[100%]
Loss of Hearing and Loss of one of: Hand, Foot or Sight of an Eye	[100%]
Loss of Both Hands, Loss of Both Feet, Loss of Sight of Both Eyes or a combination of any two of Loss of Hand, Loss of Foot or Loss of Sight of an Eye	[100%] [100%]
[Quadriplegia]	[100%]
[Paraplegia]	[75%]
[Hemiplegia]	[50%]
Loss of One Hand, Loss of One Foot or Loss of Sight of an Eye	[50%]
Loss of One Hand, Loss of One Foot or Loss of Sight of an Eye	[50%]
Loss of Speech or Loss of Hearing	
[Uniplegia]	[25%]

Loss of Thumb and Index Finger [25%]]

## [ FRACTURE BENEFIT

### What Is This Benefit?

We will pay the applicable Benefit Amount if an Accident results in a Fracture as shown below. The Accident must occur while a Covered Person is insured under this policy, while it is in force. The Fracture must be diagnosed as a Fracture by a Physician within [90, 180, 365] days after the Accident. The Fracture requires correction by a Physician. It can be corrected by Open (surgical) or Closed (non-surgical) Reduction.

If a Covered Person sustains more than one Fracture in an Accident, and requires Open or Closed Reduction, payment will be made for all Fractures. However, payment will not exceed more than two times the amount of the bone involved which has the highest Benefit Amount as shown below.

If the Physician diagnoses a Chip Fracture, We will pay a reduced benefit as shown below.

[If a Covered Person sustains a Fracture and a Dislocation in the same Accident, payment will be made for both. However, payment will not exceed two times the amount of the bone or joint involved which has the highest Benefit Amount.]]

### How much insurance is provided?

#### [Class] [1]

<u>Fracture</u>	<u>Closed/Open Reduction Benefit Amount for each Fracture</u>
Skull-depressed (except bones of the face or nose)	<u>\$XXXX/XXXX</u>
Skull-simple (except bones of the face or nose)	<u>\$XXXX/XXXX</u>
Hip or thigh (femur)	<u>\$XXXX/XXXX</u>
Pelvis (except coccyx), Vertebrae (except processes), Leg (tibia and/or fibula),	<u>\$XXXX/XXXX</u>
Vertebral processes	<u>\$XXXX/XXXX</u>

Arm, between shoulder  
and elbow (shaft) \$XXXX/XXXX

Upper Jaw, Maxilla  
(except Alveolar Process) \$XXXX/XXXX

Shoulder blade (scapula),  
Collarbone (clavicle, sternum) \$XXXX/XXXX

Knee cap (patella), Ankle,  
Foot (except toes) \$XXXX/XXXX

Forearm (radius or ulna),  
hand or wrist (except fingers) \$XXXX/XXXX

Lower jaw (except alveolar process) \$XXXX/XXXX

Rib \$XXXX/XXXX

Bones of face or nose \$XXXX/XXXX

Finger, Toe \$XXXX/XXXX

Coccyx \$XXXX/XXXX

Skull-depressed  
(except bones of the face or nose) \$XXXX/XXXX

Skull-simple  
(except bones of the face or nose) \$XXXX/XXXX

Hip or thigh (femur) \$XXXX/XXXX

If the Physician diagnoses a Chip Fracture, We will pay [25%] of the Closed Reduction amount listed above.] ]

## [ **DISLOCATION BENEFIT**

### **What Is This Benefit?**

We will pay the applicable Benefit Amount if an Accident results in a Dislocation as shown below. The Accident must and occur while a Covered Person is insured under this policy, while

it is in force. The Dislocation must be diagnosed by a Physician within [90, 180, 365] days after the Accident. The Dislocation requires correction with anesthesia by a Physician. It can be corrected by Open (surgical) or Closed (non-surgical) Reduction.

If a Covered Person sustains more than one Dislocation in an Accident, and requires Open or Closed Reduction, payment will be made for all Dislocations. However, payment will not exceed more than two times the amount of the joint involved which has the highest Benefit Amount as shown below.

If the Dislocation requires reduction without anesthesia by a Physician, We will pay a reduced benefit as shown below.

This benefit will only be paid once for the first Dislocation of a joint after the Covered Person's effective date of coverage. Subsequent Dislocations of the same joint after such effective date will not be covered.

[If a Covered Person sustains a Fracture and a Dislocation in the same Accident, payment will be made for both. However, payment will not exceed two times the amount of the bone or joint involved which has the highest Benefit Amount.]]

#### **How much insurance is provided?**

[Class] [1]

<u>Dislocation</u>	<u>Closed/Open Reduction Benefit Amount for each Dislocation</u>
Hip	<u>\$XXXX/XXXX</u>
Knee (except patella)	<u>\$XXXX/XXXX</u>
Ankle-bone(s) of foot (except toes)	<u>\$XXXX/XXXX</u>
Collarbone (sternoclavicular)	<u>\$XXXX/XXXX</u>
Lower Jaw, Shoulder, Elbow or Wrist	<u>\$XXXX/XXXX</u>
Hand bone(s) (except fingers)	<u>\$XXXX/XXXX</u>
Collarbone (Acromioclavicular and separation)	<u>\$XXXX/XXXX</u>
One finger or one toe	<u>\$XXXX/XXXX</u>

If the Dislocation requires reduction without anesthesia by a Physician, We will pay [25%] of the Closed Reduction amount listed above.] ]

## [ TENDON(S)/LIGAMENT(S)/ROTATOR CUFF(S) BENEFIT

### What Is This Benefit?

We will pay the Benefit Amount as shown below if:

- 1) a Covered Person's Accident results in injuries to a tendon, ligament, or rotator cuff;
- 2) the tendon, ligament or rotator cuff is torn, ruptured or severed; and
- 3) must be repaired through surgery by a Physician within [90, 180, 365] days after the Accident.

The Accident must and occur while a Covered Person is insured under this policy, while it is in force.

If exploratory surgery is performed and no repair is done, We will pay the benefit entitled Exploratory Surgery without repair as shown below in lieu of the Tendons/Ligament/Rotator Cuff Benefit Amount.

If a Covered Person sustains a Fracture or a Dislocation and tears, ruptures, or severs a tendon, ligament, or rotator cuff in the same Accident, only one benefit is payable. The larger of the Tendons/Ligament/Rotator Cuff Benefit, the Fracture benefit or the Dislocation benefit will be payable. [In addition, if the Covered Person is covered for the Surgical Indemnity Benefit and benefits for either repair or Exploratory Surgery without repair would be covered under the Surgical Indemnity Benefit, the Covered Person will be entitled to the larger Benefit Amount but not both benefits.]]

### How much insurance is provided?

Class	Benefit Amount
Torn, Ruptured or Severed Tendon / Ligament / Rotator Cuff	
Surgical repair: one tendon/ligament/rotator cuff	\$XXX per Accident
Surgical repair: two or more tendons/ligaments/rotator cuffs	\$XXX per Accident
Exploratory Surgery without repair	\$XXX per Accident]

## [ TORN KNEE CARTILAGE BENEFIT

### What Is This Benefit?

We will pay the Benefit Amount as shown below if a Covered Person's Accident results in a torn knee cartilage (meniscus). The torn knee cartilage (meniscus) must be treated by a Physician within [X] days after the Accident. It must be repaired through surgery by a Physician within six months after the Accident. One benefit will be paid for each Accident. If Exploratory Surgery without repair is performed and no repair is done, or if the cartilage is shaved (debridement), the benefit entitled Exploratory Surgery without repair as shown below will be paid in lieu of the Torn Knee Cartilage (meniscus) Benefit. [In addition, if the Covered Person is covered for the Surgical Indemnity Benefit and benefits for either repair or Exploratory Surgery without repair would be covered under the Surgical Indemnity Benefit, the Covered Person will be entitled to the larger Benefit Amount but not both benefits.]]

### How much insurance is provided?

Torn Knee Cartilage With surgical repair	Benefit Amount \$XXX per knee per <b>Accident</b>
Exploratory Surgery without repair	\$XXX per knee per <b>Accident</b> ]

### [ **REDUCTION OF BENEFIT AMOUNT FOR ALL BENEFITS PROVIDED**

### Do Benefits reduce at certain ages?

[If a Covered Person is age [70] or older on the date of a loss covered under this policy, the benefit otherwise payable will be reduced according to the following schedule:

### How much insurance is provided?

Age on Date of Loss:	Amount of Benefit Amount after Reduction:
65	[50%] of the Benefit Amount otherwise payable to the Covered Person]
[75]	[25%] of the Benefit Amount otherwise payable to the Covered Person]

[The Benefit Amount cannot be increased by You after age [sixty-five (65)].]

### WHAT DEFINITIONS APPLY TO MY COVERAGE?

The following definitions are important to Your benefits:

[Accident or Accidental] means a sudden, unforeseen, and unexpected event which happens by chance, arises from a source external to the Covered Person, is independent of illness, disease or



other bodily malfunction or medical or surgical treatment thereof; occurs while the Covered Person is insured under this policy which is in force; and is the direct cause of loss.] [Advanced Diagnostic Test] means the following tests: Angiogram /Arteriogram, EEG, Myelogram, CT Scan, MRI Scan, and PET Scan.] [Benefit Amount] means the amount stated in the provision entitled WHAT BENEFITS ARE INCLUDED? for a benefit covered under this policy for a Covered Person. [Calendar Year] means the period of time starting on January 1 and ending on December 31.][Chip Fracture means a small chip of a bone being torn away by the tendon or ligament. It is also known as an avulsion fracture.] [Class] means the categories of Covered Persons described on page 1 of the Description of Coverage. [Common Carrier] means any motorized land, water or air Conveyance, organized and licensed for the transportation of passengers for hire and operated by an employee or an individual under contract. ] [Company] means Federal Insurance Company. [Complications of Pregnancy] means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are: 1) acute nephritis or nephrosis; and 2) cardiac decompensation or missed abortion; and 3) similar medical and surgical conditions of comparable severity; and 4) non-elective caesarean section; and 5) termination of an ectopic pregnancy; and 6) spontaneous termination when a live birth is not possible. (This does not include elective abortion.)) [Confined or Confinement] means being admitted to a Hospital to receive inpatient services for which the Covered Person is charged at least one day's room and board by the Hospital. Confinement consists of consecutive days of Confinement following the date the Covered Person is admitted as an inpatient in a Hospital. ] [Conveyance] means any motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority with competent jurisdiction.] [Covered Person] means You [and Your insured Dependents.] [Dependent] means Your Dependent Child, Your Spouse [, or Your Domestic Partner] .] [Dependent Child] means Your unmarried child from the moment of birth, including a natural child, grandchild, stepchild or adopted child from the date of placement with You. The Dependent Child must be primarily dependent upon You for maintenance and support, and must be:1) under the age of [nineteen (19)]; 2) under the age of[ twenty-five (25)] if enrolled as a full-time student at an Institution of Higher Learning; or 3) classified as an Incapacitated Dependent Child. ] [Description of Coverage Year] means the consecutive twelve (12) month period starting with the Insured Person's effective date of coverage under this policy and ending on the day before the anniversary date of such effective date.] [Dislocation] means a completely separated joint.] [Domestic Partner] means a person designated [at enrollment] by You who is registered as a Domestic Partner or legal equivalent under laws of the governing jurisdiction or who is at least [eighteen (18)] years of age and competent to enter into a contract; is not related to You by blood; has exclusively lived with You for at least [twelve (12) consecutive months] prior to the date of enrollment; is not legally married or separated; and as of the date of enrollment, has with You at least two (2) of the following financial arrangements: a) a joint mortgage or lease; b) a joint bank account; c) joint title to or ownership of a motor vehicle or status as a joint lessee on a motor vehicle lease; or d) a joint credit card account with a financial institution. Neither You nor the Domestic Partner can be married to, nor in a civil union with, anyone else. ] [Elimination Period] means the consecutive amount of time, shown the provision entitled WHAT BENEFITS ARE INCLUDED?, that must elapse before a Benefit Amount becomes payable. The Elimination Period begins on the first day of a Covered Person's In-Hospital Confinement. [Benefit Amounts are not payable, nor do they accrue, during an Elimination Period.]] [Emergency Medical Care] means the sudden onset of a medical condition due to [Accident or]

Sickness for which the Covered Person seeks immediate medical care at the nearest available facility. The condition must be one that manifests itself by acute symptoms that are sufficiently severe that, without immediate medical attention, could reasonably be expected to result in: placing the Covered Person's health in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily organ or part.] Experimental or Investigational means the service, supply, care or treatment has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication and has not been approved or accepted as essential to the treatment of [ an Accident or] Sickness by any of the following: 1) The American Medical Association 2) The United States Surgeon General 3) The United States Department of Public Health 4) The National Institutes of Health Medicare Fracture means a break in a bone which can be seen by X-ray.] Hemiplegia means complete and irreversible loss of all motion and all practical use of one arm and one leg on the same side of the body that lasts longer than [365 days] as determined by a Physician approved by Us.] Hospital means a public or private institution which: 1) is licensed in accordance with the laws of the jurisdiction where it is located; 2) is accredited by the Joint Commission on Accreditation of Hospitals; 3) operates for the reception, care and treatment of sick, ailing or injured persons as in-patients; 4) provides organized facilities for diagnosis and medical or surgical treatment; 5) provides twenty-four (24) hour nursing care; 6) has a Physician or staff of Physicians; and 7) is not primarily a day clinic, rest or convalescent home, assisted living facility or similar establishment and is not, other than incidentally, a place for the treatment of alcoholics or drug addicts.] [Hospital includes a Rehabilitation Facility [except a facility that is exclusively a treatment facility for alcoholism or drug or substance abuse or a detoxification facility.]] Immediate Family Member means Your 1) Spouse [or Domestic Partner]; 2) children including adopted children or stepchildren; 3) legal guardians or wards; 4) siblings or siblings-in-law; 5) parents or parents-in-law; 6) grandparents or grandchildren; 7) aunts or uncles; 8) nieces and nephews. Immediate Family Member also means a Spouse's [or Domestic Partner's] children, including adopted children or stepchildren; legal guardians or wards; siblings or siblings-in-law; parents or parents-in-law; grandparents or grandchildren; aunts or uncles; nieces or nephews. Incapacitated Dependent Child means a child who, as a result of being mentally or physically challenged, is permanently incapable of self-support and permanently dependent on You for support and maintenance. The incapacity must have occurred while the child was: 1) under the age of [nineteen (19)]; or 2) under the age of [twenty-five (25)] if enrolled as a full-time student at an Institution of Higher Learning. ]In-Hospital means registered as an in-patient and Confined to a Hospital while being treated by a Physician. In-Hospital does not include confinement solely for convalescent or nursing care. Intensive Care Unit means only that specifically designated facility of the Hospital that provides the highest level of medical care. It is restricted to patients who are critically ill or injured. The Intensive Care Unit must be listed in the current edition of the American Associate Guide or eligible to be listed therein. This guide lists three types of facilities that meet the definition of Intensive Care Unit: 1)Intensive Care Unit; 2) Cardiac Intensive Care Unit; and 3) Infant (neonatal) Intensive Care Unit. Institution of Higher Learning means any accredited public or private college, university, professional trade or vocational school beyond the twelfth (12) grade.] Loss means Accidental: Loss of Foot, Loss of Hand, Loss of Hearing, Loss of Life, Loss of Sight, Loss of Sight of One Eye, Quadriplegia, Paraplegia, Hemiplegia, Loss of Speech, Uniplegia, Loss of Thumb and Index Finger Loss must occur within one (1) year after the Accident.] Loss of Foot means the complete severance of a foot through or above the ankle joint. We will consider such severance a Loss of Foot even if the

foot is later reattached. If the reattachment fails and amputation becomes necessary, then We will not pay an additional Benefit Amount for such amputation.][Loss of Hand means complete severance, as determined by a Physician, of at least four (4) fingers at or above the metacarpal phalangeal joint on the same hand or at least three (3) fingers and the thumb on the same hand. We will consider such severance a Loss of Hand even if the hand, fingers or thumb are later reattached. If the reattachment fails and amputation becomes necessary, then We will not pay an additional Benefit Amount for such amputation.] [Loss of Hearing means permanent, irrecoverable and total deafness, as determined by a Physician, with an auditory threshold of more than 90 decibels in each ear. The deafness cannot be corrected by any aid or device, as determined by a Physician.] [Loss of Life means death, including clinical death, as determined by the local governing medical authority where such death occurs within 365 days after an Accident.] [Loss of Sight means permanent loss of vision. Remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a Physician.] [Loss of Sight of One Eye means permanent loss of vision of one eye. Remaining vision in that eye must be no better than 20/200 using a corrective aid or device, as determined by a Physician.] [Loss of Speech means the permanent, irrecoverable and total loss of the capability of speech without the aid of mechanical devices, as determined by a Physician.] [Loss of Thumb and Index Finger means complete severance, through the metacarpal phalangeal joints, of the thumb and index finger of the same hand, as determined by a Physician. We will consider such severance a Loss of Thumb and Index Finger even if a thumb, an index finger or both are later reattached. If the reattachment fails and amputation becomes necessary, then We will not pay an additional Benefit Amount for such amputation. ] [Major Surgical Procedure means a surgical procedure required to treat [an Accident or] Sickness that requires general anesthesia with respiratory assistance.] [Mental Illness means those illnesses classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered to a Covered Person. [For purposes of the policy, Mental Illness does not include alcoholism or drug or substance abuse.] ] [Minor Surgical Procedure means a surgical procedure required to treat [an Accident or] Sickness that requires general anesthesia but no respiratory assistance.] [Outpatient Unit means a licensed treatment center that has: 1) permanent facilities; 2) a Physician present during all operating hours; and 3) ancillary services, including laboratory and X-ray, staffed during all operating hours. ] [Paraplegia means complete and irreversible loss of all motion and all practical use of both legs that lasts longer than [365 days], as determined by a Physician approved by Us.] [Period of Confinement means a period of consecutive days of In-Hospital from the date the Covered Person is admitted to the Hospital until the date of discharge. The Period of Confinement must be for at least one 24 hour period.. A Confinement for a Sickness shall not be combined with another Confinement for an Accident in determining a Period of Confinement. Physician means a licensed practitioner of the healing arts, acting within the scope of his or her license to the extent provided by the laws of the jurisdiction in which medical treatment is provided. Physician does not include: 1) the Covered Person; 2) an Immediate Family Member [; 3) the Covered Person's employer or business partner; or the Policyholder]. [Plan Year means the 12 month period of time used to determine how benefits are paid. The Plan Year is shown in the section entitled WHAT BENEFITS ARE INCLUDED?.] [Policyholder means the entity identified in the Insuring Agreement. [Policy Year means the consecutive 12 months period starting on the Policy Effective Date.] [; and 3) pays the required premium, for the insurance elected]. ] [Pre-existing Condition means a Sickness for which, in the [1-12] months before the Covered Person becomes insured under the policy

medical advice, treatment or care was sought by the Covered Person, or, was recommended by, prescribed by or received from a Physician.] Proof of Loss means written evidence acceptable to Us that [an Accident] [or] Sickness] has occurred that results in a loss covered under this Policy. Quadriplegia means complete and irreversible loss of all motion and all practical use of both arms and legs that lasts longer than [365 days], as determined by a Physician approved by Us.] Rehabilitation Facility means a public or private institution which: 1) is licensed in accordance with the laws of the jurisdiction where it is located; 2) is accredited by either the Joint Commission on Accreditation of Health Care Organizations or the Commission on the Accreditation of Rehabilitation Facilities; 3) operates for the reception, care and treatment of sick, ailing or injured persons as in-patients; 4) provides organized facilities for the rehabilitation of physical disabilities; 5) provides twenty-four (24) hour nursing care; 6) has a Physician or staff of Physicians; and 7) is not primarily a day clinic, rest or convalescent home, assisted living facility or similar establishment and is not, other than incidentally, a place for the treatment of alcoholics or drug addicts.] Sickness means a physical illness or disease [or Mental Illness] that begins while the policy is in force and is not a Pre-existing Condition. Sickness includes [pregnancy][and] Complications of Pregnancy. All Sicknesses due to the same or a related cause are considered one Sickness. Spouse means Your husband or wife who is recognized as such by the laws of the jurisdiction in which You reside. A covered Spouse is a Covered Person.] Subsidiary means any organization in which: 1) more than 50% of the outstanding securities or voting rights representing the present right to vote for election of directors is owned or controlled, directly or indirectly, in any combination by the Policyholder; or 2) the Policyholder exercises management control. ] Uniplegia means complete and irreversible loss of all motion and all practical use of one arm or one leg that lasts more than [365 days], as determined by a Physician approved by Us.] We, Us and Our means Federal Insurance Company. You, Your means an eligible [Member][Employee] who has enrolled for insurance under this Policy [and paid the premium due].

## **WHAT IS NOT COVERED?**

This insurance does not apply to any loss that is caused by or resulting from, directly or indirectly:

- 1) [any Accident caused by or resulting from, directly or indirectly, the Covered Person entering, flying or exiting any aircraft while acting or training as a pilot or crew member. This exclusion does not apply to passengers who temporarily perform pilot or crew functions in a life-threatening emergency. ]
- 2) [cosmetic surgery or care or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to cosmetic surgery [resulting from an Accident if initial treatment of the Covered Person is begun within twelve (12) months of the date of the Accident or] to treat congenital defects in covered newborns.]
- 3) [any service, supply or care that is Experimental or Investigational.]
- 4) [any Accident caused by or resulting from, directly or indirectly, a Covered Person's participation in scuba diving to depths of more than 130 feet; skydiving; hang-gliding or para-gliding; parascending other than over water; bungee jumping; mountaineering or rock climbing normally requiring the use of guides or ropes; or caving.]

- 5) [any [Accident or] Sickness caused by or resulting from, directly or indirectly, the Covered Person's commission or attempted commission of a felony or being engaged in an illegal occupation. ]
- 6) [immunization shots and routine examinations including: health exams; periodic check-ups; pre-marital exams; and routine physicals, except as otherwise covered under the policy.]
- 7) [any [Accident or] Sickness caused by or resulting from, directly or indirectly any occurrence while the Covered Person is incarcerated.]
- 8) [sex changes or the reversal of tubal ligation and vasectomies, artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications, or Physician's services, unless required by law.]
- 9) [any Accident caused by or resulting from, directly or indirectly, the Covered Person being intoxicated, at the time of an Accident. Intoxication is defined by the laws of the jurisdiction where such Accident occurs. ]
- 10) [any Accident caused by or resulting from, directly or indirectly, the Covered Person being intoxicated, while operating a motorized vehicle at the time of an Accident. Intoxication is defined by the laws of the jurisdiction where such Accident occurs. ]
- 11) Alcoholism or drug or substance abuse. In addition, the insurance does not apply to any confinement in a detoxification facility or drug or alcohol rehabilitation facility that is not also a Hospital or part of a Hospital.]
- 12) [any [Accident or] Sickness caused by or resulting from, directly or indirectly, the Covered Person being under the influence of any narcotic or other controlled substance at the time of the loss. This exclusion does not apply if any narcotic or other controlled substance is taken and used as prescribed by a Physician. ]
- 13) [Sickness caused by or resulting from a Covered Person's Pre-existing Condition if the Sickness occurs during the first [1-12] months that a Covered Person is insured under this policy. [If the Covered Person is a late enrollee, this exclusionary time period is [18] months.]]
- 14) [pregnancy, except a Complication of Pregnancy;]
- 15) [pregnancy of a Dependent Child, unless required by law.]
- 16) [any Accident caused by or resulting from, directly or indirectly, the Covered Person participating in any professional sporting activity for which the Covered Person received a salary or prize money. ]
- 17) any rest care or custodial care or treatment for any [Accident or] Sickness.
- 18) [any Accident caused by or resulting from, directly or indirectly, the Covered Person being engaged in or participating in a motorized vehicular race or speed contest. ]
- 19) [any Accident caused by or resulting from, directly or indirectly, the Covered Person traveling or flying on any rocket propelled or rocket launched conveyance.]
- 20) [any [ Accident or] Sickness caused by or resulting from, directly or indirectly, the Covered Person participating in military action while in active military service with the armed forces of any country or established international authority.]
- 21) [ related to the Covered Person's suicide, attempted suicide or intentionally self-inflicted injury.]
- 22) voluntary abortion, except with respect to You [or Your covered [Spouse][Domestic Partner] where such person's life would be endangered if the fetus were carried to term.

- 23) [any [Accident or] Sickness caused by or resulting from, directly or indirectly, war, undeclared war, civil war, insurrection, rebellion, revolution, warlike acts by a military force or personnel, any action taken in hindering or defending against any of these or any consequences of any of these acts regardless of any other direct or indirect cause or event, whether covered or not, contributing in any sequence to the loss.]
- 24) [routine newborn well baby care, including routine nursery charges.]
- 25) [Accident or] Sickness arising out of and in the course of any occupation for compensation, wage or profit or which are payable under Occupational Disease Law, Workers Compensation or similar law, whether or not application for such benefits have been made.

## **ARE THERE IMPORTANT THINGS TO KNOW WHEN FILING A CLAIM?**

Yes, these are the Claim Provisions:

Answers to specific questions can be obtained by writing the Plan Administrator. **To submit a claim please contact the [Plan Administrator][Policyholder].**

[Plan Administrator][Policyholder]  
[Insert here]

### **Notice of Claim:**

Written Claim Notice must be given to Us or any of Our brokers or appointed agents within twenty (20) days after the occurrence or commencement of any loss covered by this policy or as soon as reasonably possible. Notice must include enough information to identify the Covered Person and Policyholder. Failure to give Claim Notice within twenty (20) days will not invalidate or reduce any otherwise valid claim if notice is given as soon as reasonably possible.

### **Claim Forms:**

When We receive notice of a claim, We will send the Covered Person or the Covered Person's designee, within fifteen (15) days, forms for giving Proof of Loss to Us. If the Covered Person or the Covered Person's designee does not receive the forms, then the Covered Person or the Covered Person's designee should send Us a written description of the loss. This written description should include information detailing the occurrence, type and extent of the loss for which the claim is made.

### **Claim Proof of Loss:**

Complete Proof of Loss must be given to Us within ninety (90) days after the date of the loss, or as soon as reasonably possible.

We have a right to examine under oath, as often as We may reasonably require, the Covered Person, the Policyholder, the beneficiary, or the Covered Person's authorized representative. We may also require the Covered Person, the Policyholder or the beneficiary to provide a signed description of the circumstances surrounding the loss and their interest in the loss. The Covered

Person, the Policyholder and the beneficiary will also produce all records and documents requested by Us and will permit Us to make copies of such records or documents.

**Claim Payment:**

We will pay the Covered Person, beneficiary, or the Covered Person's assignee the applicable Benefit Amount within sixty (60) days after We receive complete Proof of Loss if the Covered Person, the Policyholder and beneficiary, where applicable, have complied with all the terms of this policy.

**Claim and Suit Cooperation:**

In the event of a claim under this policy, the Policyholder, the Covered Person or the beneficiary, if applicable, must fully cooperate with Us in Our handling of the claim, including, but not limited to, the timely submission of all medical and other reports, and full cooperation with all physical examinations and autopsies that We may require. If We are sued in connection with a claim under this policy, then the Policyholder, the Covered Person or the beneficiary must fully cooperate with Us in the handling of such suit. The Policyholder, the Covered Person or the beneficiary must not, except at their own expense, voluntarily make any payment or assume any obligation in connection with any suit without Our prior written consent.

**ARE THERE ANY OVER-ARCHING PROVISIONS THAT I SHOULD KNOW ABOUT?**

Yes, these are the general provisions. The following provisions apply to the Covered Persons:

**[Beneficiary:**

**A) Designation**

A Covered Person has the right to designate a beneficiary. Notwithstanding, You shall have the sole right to designate a beneficiary for any Dependent Child who is a minor. All beneficiary designations must be:

- 1) in writing;
- 2) filed with the Policyholder; and
- 3) provided to Us at the time of claim; or
- 4) at such other time as We may require.

**B) Change**

The Covered Person, and no one else, unless there is an irrevocable assignment, or such Covered Person is a minor or incapable of giving a valid release, has the right to change the beneficiary except as set forth above. The Covered Person does not need the consent of anyone to do so. All beneficiary changes must be:

- 1) in writing;
- 2) filed with the Policyholder; and
- 3) provided to Us at the time of claim or at such other time as We may require.

We do not assume any responsibility for the validity of these changes.

### C) Payment

The Benefit Amount for Loss of Life covered under this policy will be paid to the beneficiary designated by a Covered Person. Any Benefit Amount payable due to the Loss of Life of a Dependent Child will be paid to You, absent any beneficiary designation by the Dependent Child.

If a You have or a Covered Person in the case of a minor child or person who is incapable of giving a valid release has not chosen a beneficiary or if there is no beneficiary alive when the Covered Person dies, then We will pay the Benefit Amount for Loss of Life to the first surviving party in the following order:

- 1) Your Spouse [or Domestic Partner];
- 2) in equal shares to Your surviving children;
- 3) in equal shares to Your surviving parents;
- 4) in equal shares to Your surviving brothers and sisters;
- 5) Your estate.

All other Benefit Amounts are paid to You, unless otherwise directed by You or Your designee, unless otherwise noted in this policy. If You are incapable of giving a valid release for benefits payable, We will pay benefits to the Your designee or personal representative.

If any beneficiary has not reached the legal age of majority, then We will pay such beneficiary's legal guardian.]

### **Grace Period:**

The Policyholder is entitled to a grace period of [thirty-one (31) days] from the premium due date for the payment of premium due. This policy will continue in force during the grace period. The grace period does not apply to the first premium payable during this policy term. Failure to pay the first premium on or before the due date will immediately terminate this policy as of inception. We are not required to provide notification of such termination.

### **Compliance by Policyholder and Covered Person :**

We have no duty to provide insurance under this policy unless the Policyholder, the Covered Person and the beneficiary, if applicable, have fully complied with all the terms and conditions of this policy.

### **Concealment or Fraud:**

Subject to the "Time Limit on Certain Defenses" provisions, insurance under this policy is void if:

- 1) the Policyholder or any Covered Person has intentionally concealed any material fact or made a material misrepresentation relating to this policy before or after a loss;



- 2) the Policyholder or any Covered Person has intentionally concealed any material fact or made a material misrepresentation relating to a loss or benefit otherwise payable; or
- 3) the Policyholder or any Covered Person files a false report of a loss.

**Assigned Payment of Benefits:**

You may assign payment of benefits by notifying Us in writing on a form acceptable to Us of the assignment. We assume no responsibility for the validity or effect of an assignment.

**Governing Jurisdiction and Conformance with Statutes:**

This policy is governed by the laws of the jurisdiction in which it is delivered to the Policyholder. Any terms of this policy which are in conflict with the applicable statutes, laws or regulations of the jurisdiction in which this policy is delivered are amended to conform to such statutes, laws or regulations. Any terms of a Description of Coverage which are in conflict with the applicable statutes, laws or regulations of the jurisdiction in which the Description of Coverage is delivered are amended to conform to the statutes, laws or regulations of the jurisdiction.

**Legal Action Against Us:**

No legal action may be brought to recover on this policy until sixty (60) days after We have been given complete Proof of Loss. No such action may be brought after three (3) years from the time complete Proof of Loss is required to be given. No such action may be brought unless there has been full compliance with all of the terms of this policy.

In no case will We be liable for benefits that are not payable under the terms of this policy or that exceed the applicable Benefit Amounts or limits of insurance of this policy.

**Liberalization:**

If We adopt any changes:

- 1) within forty-five (45) days prior to the policy effective date shown in the WHEN DOES MY COVERAGE BECOME EFFECTIVE? Section above; or
- 2) during the Plan Year,

which broaden this insurance without an additional premium charge, then the Covered Person will automatically receive the benefit of the broadened insurance.

**Misstatement of Age:**

If the age of a Covered Person has been misstated, We will make an equitable adjustment of the premium and benefits. The premium will be the difference between the premiums paid and the premiums that would have been paid at the Covered Person's true age. If coverage would not have been provided, We will refund the premiums paid for such insurance on and terminate the insurance, if no benefits have been paid. Benefits payable will be based on the correct age and premium paid.

**Physical Examination and Autopsy:**

We have the right to have the Covered Person examined by a Physician approved by Us, as often as reasonably necessary while a claim is open. We may also have an autopsy done by a Physician, unless prohibited by law. Any examinations or autopsies that We require will be done at Our expense.

**Time Limit on Certain Defenses:**

In the absence of fraud, statements made by a Covered Person are deemed representations and not warranties. After two years from the Covered Person's effective date of coverage, no misstatements, except fraudulent misstatements, on the Covered Person's enrollment form may be used to:

- 1) void this coverage; or
- 2) deny or reduce any claim for loss that occurs after the two year period.

If a Covered Person receives an increase in any Benefit Amount, an additional two year time limit period will apply to the increase in benefits only.

**Workers' Compensation:**

The benefits payable under this policy are not in lieu of and do not affect any requirement for workers' compensation insurance.



**FEDERAL INSURANCE COMPANY**  
202 Hall's Mill Road, PO Box 1600, Whitehouse Station, New Jersey 08889

## **APPLICATION FOR INSURANCE**

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APPLICATION IS HEREBY MADE TO FEDERAL INSURANCE COMPANY  
FOR A POLICY OF GROUP INSURANCE AS PER THE PROPOSAL,  
DATED \_\_\_\_\_.

POLICYHOLDER: [\_\_\_\_\_]

ADDRESS: [\_\_\_\_\_]  
STREET CITY STATE ZIP

THIS POLICY SHALL BE MADE EFFECTIVE AT 12:01 A.M. STANDARD  
TIME ON [\_\_\_\_\_] AT THE STATED ADDRESS OF THE  
POLICYHOLDER.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature for Policyholder

\_\_\_\_\_  
Company Authorized Representative

**[Fraud Warning Notices:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or Insured Person.]

**[Notice to Arkansas, Louisiana Minnesota, New Mexico and Ohio Applicants:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.]

**[Notice to Maryland and Rhode Island Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

**[Notice to Colorado Applicants:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory agencies.]

**[Notice to Maine, Tennessee and Virginia Applicants:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.]

**[Notice to District of Columbia Applicants:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

**[Notice to Florida and Oklahoma Applicants:** Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of: a felony (in Oklahoma) or a felony of the third degree (in Florida).]

**[Notice to Kentucky Applicants:** Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.]

**[Notice to New Jersey Applicants:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

**[Notice to Oregon and Texas Applicants:** Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.]

**[Notice to New York and Pennsylvania Applicants:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to: a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation (in New York) or criminal and civil penalties (in Pennsylvania).]

**[Notice to Washington Applicants:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of insurance benefits.]



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**Endorsement****Change**

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**Effective Date:** [01-01-13]  
**Policy Number:** [1234-56-7890]  
**Policyholder:** [ABC, Inc.]  
**Policy Period:** [01-01-13 to 01-01-14]  
**Name of Company:** **[Federal Insurance Company]**  
**Issue Date:** [01-01-13]

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It is agreed that the Policy is amended as follows:

*[Only approved wording will be used to make changes to the contract. Listed below are examples of changes that may be made.]*

- [A] Section I-Insurance of the Contract is amended to include the following:]
- [B] Section V- Definitions of the Contract is amended as follows: ]
- [C] Section I-Covered Persons of the Schedule of Benefits is [amended to include the following]  
[deleted and replace with the following]: ]
- [D] Section II-Benefits of the Schedule of Benefits is amended to include the following: ]
- [E] Section III-General Exclusions of the Contract is amended as follows: ]
- [F] The Policyholder Name and Address, found in Section I of the Insuring Agreement, is changed to the following: ]

---

All other terms and conditions of the policy remain unchanged.



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Authorized Representative



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**Endorsement****Trust Participant Endorsement**

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**Effective Date:** [01-01-02]  
**Policy Number:** [1234-56-7890]  
**Policyholder:** [ABC, Inc.]  
**Policy Period:** [01-01-02 to 01-01-03}  
**Name of Company:** **[Federal Insurance Company]**  
**Issue Date:** [12-01-02]

---

It is agreed that the Policy is amended as follows:

- 1) The following definition is added to Section IV of the Contract, Definitions:

*Participant*

**Participant** means any entity which has agreed to be bound by the terms and conditions of the trust shown in the Insuring Agreement.

- 2) The definition of **Policyholder**, found in Section IV of the Contract, Definitions, is amended to include **Participant**.

---

All other terms and conditions of the policy remain unchanged.

A handwritten signature in black ink, consisting of a series of loops and strokes, positioned above the text 'Authorized Representative'.

Authorized Representative

**CONSUMER INFORMATION NOTICE**

Policyholder Service Office of Federal Insurance Company

Address: <administrator's name if company not handling Policyholder Service>  
<mailing address>

Telephone Number: <toll-free number if available>

Agent (to be completed at time of enrollment)

Name of Agent: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

If we at Federal Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department  
Consumer Services Divisions  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
Phone: (501) 371-2640

<b>SERFF Tracking #:</b>	CLTR-128819794	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	ASHIP5000
<b>State:</b>	Arkansas	<b>Filing Company:</b>	Federal Insurance Company		
<b>TOI/Sub-TOI:</b>	H21 Health - Other/H21.000 Health - Other				
<b>Product Name:</b>	ACCIDENT AND SICKNESS LIMITED BENEFIT CASH POLICY				
<b>Project Name/Number:</b>	Chubb-ASHIP/Chubb-ASHIP				

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	Flesch Certification	Approved-Closed	01/03/2013
Comments:			
Attachment(s):			
AR Readability Certification.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
Bypassed - Item:	Application	Approved-Closed	01/03/2013
Bypass Reason:	New application - ASHIP3000; attached under Form Schedule tab.		

		<b>Item Status:</b>	<b>Status Date:</b>
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	01/03/2013
Bypass Reason:	N/A - Group insurance.		

		<b>Item Status:</b>	<b>Status Date:</b>
Bypassed - Item:	Outline of Coverage	Approved-Closed	01/03/2013
Bypass Reason:	N/A - Group insurance.		

		<b>Item Status:</b>	<b>Status Date:</b>
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	01/03/2013
Bypass Reason:	N/A - Not PPACA Related		

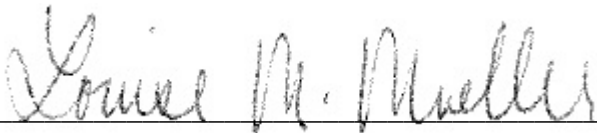
		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	Filing Authorization	Approved-Closed	01/03/2013
Comments:			
Attachment(s):			
ASHIP - Coulter filing authorization (12-14-2012).pdf			



CERTIFICATION OF COMPLIANCE  
FOR  
READABILITY

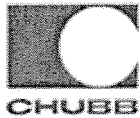
<u>Form Number(s)</u>	<u>Form Name</u>	<u>Flesch Readability Score</u>
ASHIP-5000	Accident and Sickness Limited Benefit Cash Policy	50.9
ASHIP5000-DOC AR	Description of Coverage	50.8
ASHIP-1001	Endorsement	57.7
ASHIP-1002	Trust Participant Endorsement	56.6

I hereby certify on behalf of Federal Insurance Company that the Flesch Scale Analysis Readability Score is accurate, based on the computer program used to calculate the scores. I further certify that in my judgment, the enclosed forms are readable under the rules and standards of your State.

Signature: 

Typed Name and Title: Louise Mueller, Assistant Vice President

Date: December 19, 2012



## CHUBB GROUP OF INSURANCE COMPANIES

15 Mountain View Road, Warren, NJ 07059

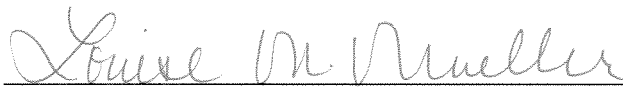
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December 14, 2012

To: State Insurance Departments

Subject: Filing Authorization for Coulter & Associates

Federal Insurance Company has engaged the services of Coulter & Associates to assist with its form and rate filings. I hereby authorize Coulter & Associates to represent Federal Insurance Company in regard to this filing in your state.

Signature   
By: Louise M. Mueller  
Title: Assistant Vice President, U.S. Insurance Regulatory Compliance

Chubb & Son  
a division of Federal Insurance Company, Manager